An Inventory & Environmental Scan of Evidence-Based Practices for Treating Persons in Early Stages of Serious Mental Disorders

February 10, 2015

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Introduction

The Fiscal Year 2014 SAMHSA appropriation (part of the Consolidated Appropriations Act, 2014) includes a new requirement within the Mental Health Block Grant (MHBG) that "States shall expend at least five percent of the amount each receives… to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset." Congress specifically provided an increase to the MHBG over prior-year levels to help states meet this new requirement without losing funds for existing services.

The set aside was intended to stimulate state programming to better identify and more adequately respond to individuals who are experiencing their first episode of serious mental illness. Earlier and more assertive responses to these individuals are intended to help reduce the disability that these individuals will ultimately experience and to assist them in pursuing their life goals with appropriate treatment and support. Often persons receiving care, especially from public systems, are required to meet criteria for serious and persistent mental illnesses to access care. Individuals meeting these criteria generally have significant, long-term disabilities. While delivering services for persons with serious and disabling illnesses continues to be an important role for state mental health systems, the development of responsive programming to first episode consumers may eventually reduce the rates at which they become disabled, benefitting both the client and the treatment system.

This inventory reviews a variety of programs and practices to address early stages of serious mental disorders, including schizophrenia, bipolar and affective disorders, as well as other serious mental illnesses. A majority of research and program models, both in the United States and internationally, have focused on addressing First Episode Psychosis (FEP), with an emphasis on programs for persons with non-affective psychosis.

FEP programs implemented in the United States, Australia, Canada, the United Kingdom, and Scandinavia have been shown to improve symptoms, reduce relapse and prevent deterioration and disability. In the NIMH-supported studies, common components of these FEP programs include practices such as assertive community treatment, psychotherapy, supported employment and education, family education and support, and low dosages of antipsychotic medications all delivered as parts of a Coordinated Specialty Care (CSC) model. The inclusion criteria for clinical trials of CSCs have included persons who are ill with non-organic and non-affective psychotic disorders for five or fewer years. CSCs are typically targeted toward individuals ages 12 to 35, and are designed to coordinate existing services, including primary medical care, and to eliminate service gaps based on age group. They emphasize collaboration with clients to develop shared treatment goals, sometimes employing shared decision-making approaches to address preferences and recovery goals. CSCs coordinate activities with a multi-disciplinary treatment team and often involve family members as key supports.

To help states best use the five percent MHBG Set Aside in the most efficacious manner, SAMHSA and the National Institute of Mental Health (NIMH) have reviewed the evidence supporting specific practices as effective in reducing the impacts of the first episodes of psychotic illnesses and promoting improved functioning. As a result of this collaboration, NIMH and SAMHSA have released information and provided training webinars to states on promising or evidence-based (EBP) treatments for first episode psychosis. Based on the experience of a multi-site research study—Recovery After an Initial Schizophrenia Episode (RAISE), the SAMHSA-NIMH review identified a number of EBPs that can be provided as components of a Coordinated Specialty Care (CSC) program to address First Episode Psychosis.

This document, produced independently of the SAMHSA-NIMH review, provides an inventory that includes examples of U.S. and international early intervention programs for serious mental illnesses (Matrix A), as well as specific EBPs that either: a) have been tested as being effective for persons in early stages of illness (and/or b) have been identified as important components of these coordinated care early intervention models, even if the practice itself may have originally been developed for a broader population beyond persons in the early stages of illness (Matrix B). The early intervention models in Matrix A include collaborative, recovery-oriented approaches that are multicomponent. While most of the intervention programs listed focus mainly on non-affective psychosis, there are also programs listed at the end of Matrix A that are not specific to psychosis, and instead focus on depression and bi-polar disorders. In the listing of individual practices that appear in Matrix B, activities with a stronger evidence base are listed in the first part of the chart, with a set of "promising practices" at the end. A section on "Selected Additional Resources" is also provided following the matrices to offer information on various organizations, publications, webinars, and research that is relevant to the topic of addressing early stages of serious mental disorders.

Methodology

A variety of approaches were used to identify programs and practices that address early stages of serious mental disorders, including contact with program directors and internet searches to identify programs/models and glean information about each. Additionally, SCOPUS searches were employed to identify published literature on early intervention or related programs with a particular emphasis on identifying review papers addressing important aspects of early intervention programming.

Project staff contacted the program directors of a selection of emerging or current evidence-based models that address early stages of serious mental illness (EDAPT/SacEDAPT, FIRST, RAISE Connection, RAISE NAVIGATE, OnTrackNY, EASA, PREP/BEAM, OASIS, Yale STEP, and Calgary EPTS). These program directors, many of which were already known to project staff through their participation in Robert Wood Johnson Foundation/NIMH/SAMHSA's September 2014 Prodromal and Early Psychosis Prevention Network Meeting, were asked to complete a brief voluntary questionnaire about their program or programs. The questionnaire requested the following information:

- Please indicate the designated target population for your program, including any information on the diagnoses addressed or other clinical or demographic characteristics.
- How does your program identify, recruit, and/or "screen-in" program participants, including public education/awareness strategies that may be employed?
- What array of treatment services and supports make up your program model (and if the model includes specific evidence-based practices, please list the EBPs)?
- Are there strategies in place to help ensure fidelity to your program model (and/or to specific EBPs included within that model)? If so, please describe (e.g., what process is in place, what fidelity measures are used, who conducts the fidelity measurement, how frequently is fidelity measured, etc.)?
- Are peers involved in your model? IF so, please describe their role.
- Is the program time-limited, and if so, what is the duration of care?
- What outcome measures does the program use to document impact; are there outcomes that can be shared?

- Does the program model operate in a single area, or are there clinical sites across the state and/or country? Please indicate the span.
- Is your program model affiliated with a university? If so, please name.
- Please describe the types of training materials that your program has (e.g., for start-up site locations, providers, consumers, families, referral sources, etc.), and please provide a web address/URL if those materials are publicly available.
- To your knowledge, is your model being used by your state (or other states) in conjunction with the five-percent Mental Health Block Grant Set-Aside Requirement? If yes, please indicate if/how you are working with the states to meet this new requirement.
- A list or copy of any published or unpublished studies or reports that should be included in the environmental scan.

A copy of each of the profiles that were submitted by these program representatives is included in the Appendix.

In addition to the Appendix material, a matrix of coordinated specialty care (CSC) programs was constructed that summarizes important features of the programs from the program directors' responses to the questionnaire. Additionally, a web-based search was conducted to identify additional programs of interest, beyond those for which the program directors provided information. The results of these web-based searches and related materials are also included in the matrix, with varying amounts of available information across the different programs. Keywords and phrases used in the internet search include:
- Coordinated Specialty Care in First Episode Psychosis
- Program Models to Treat First Episode Psychosis
- Early Psychotic Episode
- Evidence-based Programs to Treat First Episode Psychosis
- First Episode Psychosis
- Early Intervention to Treat Mood Disorders

The majority of sources included in the matrix are available for download from each of the program's websites. In the electronic version of this document, many of these sources' URLs are embedded to facilitate access.

Many of the CSC programs share similar arrays of evidence-based practices. Material on these practices was also obtained from web searches. A review of the literature related to the most prominent of these practices was also conducted. Information for this matrix was gleaned through internet and database searches. Keywords used include:
- [EBP name] and schizo*
- [EBP name] and bipolar
- [EBP name] and early psychosis
- [EBP name] and treatment manual
- [EBP name] and certification requirements
- [EBP name] and toolkit
- [EBP name] and fidelity
- [EBP name] and outcomes

Many of these practices were originally developed for work with individuals who have experienced disability related to their psychiatric condition. SAMHSA and the National Institute of Disability and Rehabilitation Research have supported national research and technical assistance centers that have focused on developing and testing interventions for persons with serious mental illnesses. The websites from the three national centers were searched to identify material that could be useful to states in implementing first episode programs. Some of these materials with web links, when available, are included in the Selected Additional Resources section of this scan. A website search of other national and international mental health organizations was conducted to identify various other publicly-available reports, fact sheets, guidelines, and similar tools related to addressing the needs of persons in early stages of illness. These resources include information targeted toward consumers, families, providers, and referral sources, and links to access these items are also provided in the Selected Additional Resources section.

In an attempt to identify recently published reviews of the literature related to several of the individual components of early intervention programs, a SCOPUS literature review was completed. The search was restricted to review articles published during the 2013-2014 calendar year with key search phrase "First Episode Psychosis." Review of the abstracts resulted in identifying papers of interest that are also presented in the Additional Material section of the scan.

Limitations

This environmental scan is designed to provide information and resources that may be useful to states as they implement programs and services for persons in early stages of serious mental disorders. Since this is a developing field, there are some knowledge and practice gaps in the literature that might be less evident in more mature literatures. Therefore users of this guide should be aware of some limitations.

- Matrix A presents a representative sample of program models that use a coordinated care approach for serving persons in early stages of illness. These programs vary from one another with regard to target population parameters, length of care, etc. As such, it is not clear how generalizable these programs models are across populations or settings but they are featured as illustrative of successful attempts to serve this heterogeneous group of individuals.

- Matrix B includes information on various evidence-based practices (EBPs) that are often included within coordinated care programs for persons in their first episode of illness. Many of the resources provided in this chart, however, were not originally developed for first episode consumers but for other groups – often with more severe illness-related disabilities.

These limitations in the environmental scan highlight potential areas of exploration and needed areas for resource development.

Matrix A: Examples of Coordinated Care Models for Persons in Early Stages of Illness

Coordinated Specialty Care (CSC) as defined by the National Institute of Mental Health is a "team-based, multi-element approach to treating first episode psychosis[1]". This section contains a selection of domestic and international CSCs aimed at treating first episodes of psychosis that occur as a result of a serious mental illnesses, including (but not limited to) schizophrenia, schizoaffective disorder, and schizophreniform disorder. This matrix is **not** intended to serve as an exhaustive listing of all of the individual CSC models or clinic sites across the globe, but rather to offer a representational sampling of programs utilizing this type of model. When available, eligibility criteria, treatment components, team staffing, and online resources are provided for each program (In the electronic version, web-links are embedded).   Resources categorized under "Special Features" are developed by the program; other resources that are provided were developed by other sources, but are useful in implementing the CSC. Of course, a coordinated care approach is *also* beneficial to persons in early stages of other types of mental disorders beyond psychosis. At the end of this matrix, then, are examples of three integrated care program models that focus on mood disorders (one on bipolar, and two other on youth depression).

Program	Eligibility Criteria (May Vary by Treatment Location)	Treatment Components	Team Staffing (May Vary by Treatment Location)	Resources

Sacramento EDAPT (SacEDAPT): Similar to EDAPT, SacEDAPT is a recovery-based treatment approach that provides for two years of services focusing on 1) reducing and managing symptoms, and 2) improving individuals' ability to achieve success in independent roles. Gold standard assessments of clinical symptoms and psychosocial functioning are used to evaluate each client to determine appropriate diagnosis in order to guide treatment. This program is specifically designed for residents in Sacramento County, California, who receive Medi-Cal (California's Medicaid program), or are uninsured or undocumented. [Note: program serves both FEP and high-risk populations]. Click Early Diagnosis and Preventive Treatment (EDAPT) & Sacramento EDAPT (SacEDAPT) for a more thorough description of this program.
 	
Program Established in 2011.
 	
Contact: Tara Niendam, Ph.D.
Tel: 916-734-3090 / tniendam@ucdavis.edu
http://earlypsychosis.ucdavis.edu/edapt
Located at the Behavioral Health Center
University of California Davis Medical Center
2230 Stockton, Blvd
Sacramento, CA 95817
	• Ages 12-30
	• Residents of Sacramento County
	• Non-affective and affective psychosis
	• Experienced symptoms in the past year
	• Have Medi-Cal or are uninsured and/or undocumented
	• Also serves prodromal clients
		• Medication Management
		• Individual/Family Psychoeducation and support
		• Multi-family groups
		• Supported Education
		• Supported Employment
		• Peer Support Groups
		• Family Support groups
		• Individual and Group Cognitive Behavioral Therapy
		• Substance Abuse Management Groups
			• Clinic Director
			• Director of Operations
			• Medical Director
			• Clinic Coordinator
			• Licensed Clinical Social Worker
			• Licensed Marriage and Family Therapist
			• Peer Advocate
			• Supported Education/ Employment Specialist
				SPECIAL FEATURES:
				• *For Professionals*:
				  o Fellowships, internships, and externships for professionals are available through the EDAPT program.
				• *Outreach and Screening Materials:*
				  o Online 21 Question Screening Survey
				  o Educational sessions for stakeholders and practitioners are available through the EDAPT program at UC Davis.
				  o How to access services
				
				OUTCOME MEASURES/INSTRUMENTS:
				• Change in clinical symptom severity is monitored using the following instruments:
				  o Global Functioning Scale – Social and Role
				  o CGI-SCH (Haro, 2008; Masand, O'Gormon, & Mandel, 2011)
				  o Columbia Suicide Severity Rating Scale (CSSRS)
				• Outcomes are also measured based on the following indicators:
				  o Participation in age-appropriate social

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[1] Heinssen, R.K., Goldstein, A.B., and Azrin, S.T. (2014). *Evidence-based treatments for first episode psychosis: Components of coordinated specialty care*. Bethesda, MD: National Institute of Mental Health, National Institutes of Health. White paper available online at http://www.nimh.nih.gov/health/topics/schizophrenia/raise/nimh-white-paper-csc-for-fep_147096.pdf.

Program	Eligibility Criteria (May Vary by Treatment Location)	Treatment Components	Team Staffing (May Vary by Treatment Location)	Resources
				relationships o Rates of employment o Graduation o Homelessness o Hospitalization o Out of home placement
Early Diagnosis and Preventive Treatment (EDAPT): Recovery-based treatment approach provides for two years of services focusing on 1) reducing and managing symptoms, and 2) improving individuals' ability to achieve success in independent roles. Clinical assessment tools are used to evaluate each client to determine appropriate diagnosis in order to guide treatment. Assessments of psychological functioning also determine areas where targeted treatment is needed. Length of treatment is two years. [Note: program serves both FEP and high-risk populations]. Click Early Diagnosis and Preventive Treatment (EDAPT) & Sacramento EDAPT (SacEDAPT) for a more thorough description of this program. Program Established in 2004. Contact: Tara Niendam, Ph.D. Tel: 916-734-3090 / tniendam@ucdavis.edu http://earlypsychosis.ucdavis.edu/edapt Located at the Behavioral Health Center University of California Davis Medical Center 2230 Stockton Blvd Sacramento, CA 95817	• Ages 12-40 • Residents of Sacramento Region • Non-affective & affective psychosis • Experienced symptoms in the past year • Have private health insurance or self-pay • Also serves prodromal clients	• Comprehensive Assessment • Medication Management • Individual/Family Psychoeducation and Support • Multi-family Groups • Peer Support Groups • Individual and Group Cognitive Behavioral Therapy • Substance Abuse Management Groups	• Clinic Director • Director of Operations • Medical Director • Clinic Coordinator • Licensed Clinical Social Worker	**SPECIAL FEATURES:** • *For Professionals*: o Fellowships, internships, and externships for professionals are available through the EDAPT program. • *Outreach and Screening Materials:* o 21 Question Screening Survey o Educational sessions for stakeholders and practitioners are available through the EDAPT program at UC Davis. o How to access services **OUTCOME MEASURES/INSTRUMENTS:** • Change in clinical symptom severity is monitored using the following instruments: o Global Functioning Scale – Social and Role o CGI-SCH (Haro, 2008; Masand, O'Gormon, & Mandel, 2011) o Columbia Suicide Severity Rating Scale (CSSRS) • Outcomes are also measured based on the following indicators: o Participation in age-appropriate social relationships o Rates of employment o Graduation o Homelessness o Hospitalization Out of home placement
FIRST Early Identification and Treatment of Psychosis Programs: FIRST Programs are comprehensive, outpatient, team-based programs aimed at improving the mental health and quality of life for individuals who have experienced a first episode of a psychotic illness by	• Ages 15-40 • Diagnosis of schizophrenia, schizoaffective disorder, Schizophreniform, or other	• Comprehensive Assessment • Psychiatric Care	• Team Leader (also provides family Psychoeducation) • Psychiatrist	**SPECIAL FEATURES:** • *For Patients and Families:* o What to expect at the initial appointment o FIRST program brochures

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Program	Eligibility Criteria (May Vary by Treatment Location)	Treatment Components	Team Staffing (May Vary by Treatment Location)	Resources
promoting early identification and providing best treatment practices as soon as possible. Length of treatment is three to five years, more as necessary (based on clients' needs and preferences). Click here for a more thorough description of this program. Program Established in 2010 (Summit County, Ohio); there are currently nine FIRST programs in northeast, northwest, and southeast Ohio. Contact: Lon C. Herman Tel: 330-325-6695 / lherman@neomed.edu http://www.neomed.edu/academics/bestcenter/bestpracticefirstepisodepsychosis Best Practices in Schizophrenia Treatment (BeST) Center Department of Psychiatry at Northeast Ohio Medical University 4202 State Route 44, P.O. Box 95 Rootstown, OH 44272	specified/unspecified schizophrenia spectrum and other psychotic disorder • Individuals should have no more than 18 months of psychotic symptoms • Additional information	• Individual Counseling • Cognitive Behavioral Techniques for Psychosis (CBt-p) • Case Management • Supported Employment • Supported Education • Family Psychoeducation • Cognitive Enhancement Therapy (will be piloting) • Community Outreach	• Two Counselors • Supported Employment/ Education Specialist • Case Manager • Some teams also include Nurses	o The BeST Kind of Help: Tools and Tips for Schizophrenia Recovery, an interactive manual developed by individuals with lived experience of schizophrenia (also in print) o FIRST Family Psychoeducation Information o The BeST Kind of Help: Tips for Family Members and Friends of Individuals Affected by Schizophrenia (also in print) • *For Professionals:* o Comprehensive training is available through the BeST Center. Initial training includes an overview of the FIRST Program for all FIRST team members, and specific training for counselors, case managers, and supported employment/education specialists, and a two-day workshop on CBt-p. o Ongoing expert consultation and training is available from BeST Center consultants/trainers for early identification and treatment of psychosis, CBT-p, Family Psychoeducation, and outreach and dissemination. o Treatment manuals are provided for each member of the FIRST Team. Remote training and online options are under development. o A FIRST Procedure Manual that includes appropriate supports for intake, tracking, data gathering, and team meetings is also available. o Monthly conference calls allow all FIRST team leaders throughout Ohio to discuss items of common interest and to develop a professional learning community. • *Outreach and Screening Materials:* o FIRST Program Brochures

Program	Eligibility Criteria (May Vary by Treatment Location)	Treatment Components	Team Staffing (May Vary by Treatment Location)	Resources
				o FIRST PowerPoint Presentations o FIRST Newsletters and Monthly e-Updates are sent to master contact of community referral sources **OUTCOME MEASURES/INSTRUMENTS:** • Outcomes are measured through the Clinician-Rated Dimensions of Psychosis Symptom Severity • Outcome Review Form
Recovery After Initial Schizophrenic Episode (RAISE) Connection **Model:** The RAISE Connection Program is designed for people experiencing unusual thoughts and behaviors, or have been hearing or seeing things that others do not. The goal of this program is to help people cope with these experiences and help them feel better. Care and treatment are provided to help individuals do better at work or at school, get along with others, and feel more in control of their lives. Length of treatment is two years. Click here for a more thorough description of this program. Program Established in 2009. Click here for a National Map of RAISE Sites. Contact: Ann Hackman Tel: 1-888-864-5458 / Connection@psych.umaryland.edu http://www.connectionprogram.org Department of Psychiatry, University of Maryland School of Medicine 110 South Paca Street Baltimore, MD 21201	• Ages 15-35 • Diagnosis of schizophrenia, schizoaffective disorder, Schizophreniform, delusional disorder, or psychosis not otherwise specified. • Experienced psychotic symptoms greater than one month, less than two years. • Commitment to program for at least one year.	• Client and Family Psychoeducation • Supported Education • Supported Employment • Medication Management • Individual Psychotherapy • Group Therapy • Peer Support • Safety Planning • Assistance Connecting to Community Resources	• Team Leader • Psychiatrist • Therapist • Substance Use Recovery Coach • Education/Employment Specialist	**SPECIAL FEATURES:** • *Outreach and Screening:* o Information on making a referral to the RAISE Connection Program o RAISE Connection Program Brochure o RAISE Connection Referral Form o Manual I: Outreach and Recruitment • *For Patients and Families:* o What to expect when a loved one receives services through the RAISE Connection Program. • *For Professionals:* o Manual II: Implementation **ADDITIONAL INFORMATION:** • NIMH RAISE Project Overview

Program	Eligibility Criteria (May Vary by Treatment Location)	Treatment Components	Team Staffing (May Vary by Treatment Location)	Resources
NAVIGATE: NAVIGATE, an evolution of the NIMH RAISE Early Treatment Program, is designed to provide early and effective treatment to individuals who have experienced a first episode of psychosis. NAVIGATE consists of both an individual treatment program, and a family component. Families provide crucial social support and act as an ally in treatment. Length of treatment is two years, more as necessary. Click here for a more thorough description of this program. Program Established in 2009. Click here for a National Map of RAISE Sites. **Contacts:** John Kane, M.D. Chairman, Department of Psychiatry The Zucker Hillside Hospital; Professor of Psychiatry and Molecular Medicine; Chairman, Department of Psychiatry Hofstra North Shore-LIJ School of Medicine 718-470-8141 psychiatry@nshs.edu Susan Gingerich navigate.info@gmail.com http://navigateconsultants.org	• Ages 15-40 • Diagnosis of schizophrenia, Schizophreniform, schizoaffective disorder, brief psychotic disorder, and psychotic disorder not otherwise specified • Individuals should be in, or recovering from, first episode of psychosis with less than six months cumulative exposure to antipsychotic treatment.	• Medication Management • Supported Employment • Supported Education • Individual Family Therapy • Individual Resilience Training (IRT)	• Project Director • Prescriber • Individual Resiliency Trainer • Family Education Clinician • Supported Employment/Education Specialist	**SPECIAL FEATURES:** • *For Professionals:* o Team Members Guide o Program Director Manual o Family Education Manual o Individual Resiliency Trainer (IRT) Manual o IRT Training Videos o Prescribers Manual o Supported Employment and Education Manual **OUTCOME MEASURES/INSTRUMENTS:** • Clinical Global Impressions-Severity Scale to assess severity of illness. • Positive and Negative Syndrome Scale and the Calgary Depression Scale for Schizophrenia to assess symptoms • Heinrich-Carpenter Quality of Life Scale to assess program impact **ADDITIONAL INFORMATION:** • NIMH RAISE Project Overview
OnTrackNY: OnTrackNY is New York State's evolution of the RAISE Connection Program. OnTrackNY is an innovative treatment program for adolescents and young adults who are experiencing their first episode of psychosis. OnTrackNY helps people achieve their goals for school, work, and relationships by offering services using a shared decision-making approach. The team provides services during a critical period, averaging about two years, based on clients' needs. Click here for a more thorough description of this program. Program Established 2009. Click here for a National Map of RAISE Sites. Contact: Lisa Dixon Tel: 646-774-8420 dixonli@nyspi.columbia.edu http://www.practiceinnovations.org/CPIInitiatives/OnTrackNY.aspx	• Ages 16-30 • Residents of New York State (for OnTrackNY) • Experienced psychotic symptoms for one week or more, but less than 24 months. • DSM-V diagnosis of schizophrenia, schizoaffective disorder, Schizophreniform, delusional disorder, other specified or unspecified schizophrenia spectrum and other psychotic disorder.	• Medication Management • Supported Education • Supported Employment • Case Management • Client Psychoeducation • Family Psychoeducation • Individual Safety Planning • Structured Behavioral Interventions (e.g., Social Skills Training, Substance Abuse Treatment, Coping Skills) • Suicide Prevention • Brief PTSD	• Team Leader • Outreach and Recruitment Coordinator • Recovery Coach • Supported Employment/Education Specialist • Psychiatrist • Nurse	**SPECIAL FEATURES:** • *Outreach and Screening Materials:* o CSC for First Episode Psychosis Manual I – Outreach and Recruitment o OnTrackNY Outreach and Recruitment Manual o Voices of Recovery Videos • *For Professionals:* o Interactive Spreadsheet to Estimate Implementation Costs (Related Article in Psychiatric Services) o Consultation services o CSC for First Episode Psychosis Manual II - Implementation o OnTrackNY Team Manual

Program	Eligibility Criteria (May Vary by Treatment Location)	Treatment Components	Team Staffing (May Vary by Treatment Location)	Resources
Center for Practice Innovations at Columbia University New York State Psychiatric Institute 1051 Riverside Drive New York, New York 10032 **OnTrackUSA:** OnTrackUSA provides manuals and other web-based resources, as well as consultation and training to programs and state agencies that would like to implement CSC teams for people with early psychosis. OnTrackUSA is an extension of OnTrackNY, and helps to implement CSC teams that provide innovative, evidence-based, recovery-oriented treatment to young people who have recently begun experiencing psychotic symptoms. Program Established 2009 Contact: Contact: Lisa Dixon Tel: 646-774-8420 dixonli@nyspi.columbia.edu http://www.practiceinnovations.org/OnTrackUSA/tabid/253/Default.aspx Center for Practice Innovations at Columbia University New York State Psychiatric Institute 1051 Riverside Drive New York, New York 10032				o OnTrackNY Psychopharmacology Manual o OnTrackNY Primary Clinician's Manual o OnTrackNY IPS Supported Employment and Supported Education Manual o OnTrackNY Recovery Coach Manual o Voices of Recovery Manual for Clinical Staff o Employment Resource Book o Contact the OnTrack Helpdesk • *Monitoring Fidelity:* o OnTrackNY summarizes routinely-available data, such as service logs, to measure fidelity. Its parent program, the RAISE Connection Program, also used client self-reports to corroborate the routinely-available data, a practice also being incorporated into OnTrackNY. For a full description, see Practical Monitoring of Treatment Fidelity: Examples from a Team-Based Intervention from People with Early Psychosis. **OUTCOME MEASURES/INSTRUMENTS:** • Primary outcomes are functioning in school/work, social functioning, and symptoms as measured in the MIRECC GAF. For copies of data collection tools and associated reports, contact Lisa Dixon (646-774-8420, dixonli@nyspi.columbia.edu). **ADDITIONAL INFORMATION:** • NIMH RAISE Project Overview • See Appendix A for a thorough listing of additional materials.
The Early Assessment and Support Alliance (EASA): EASA is a coordinated statewide network of programs in Oregon that provides information and support to young people who are experiencing symptoms of psychosis for the first time. EASA is an early intervention program serving young people who have had their first experience of	• Ages 12-25 • Residents of Oregon (including college students in other states whose families live in Oregon) • Individuals who screen into the	• Community Education and Proactive Engagement • Cognitive Behavioral Therapy	• Program Director • Clinical Supervisor • Clinical Case Manager • Psychiatrist/Prescribing Nurse Practitioner	**SPECIAL FEATURES:** • *Outreach and Screening Materials:* o What psychosis is, identifying symptoms o EASA Program Referral Form o Assessment Input Form

Program	Eligibility Criteria (May Vary by Treatment Location)	Treatment Components	Team Staffing (May Vary by Treatment Location)	Resources

psychosis within the last twelve month. It is a transitional program that provides services for approximately two years. Click here for a more thorough description of this program.
 	
Program Established 2001
 	
Contact: Tamara G. Sale
Tel: 503-726-9620 / tsale@pdx.edu
http://www.easacommunity.org
Regional Research Institute
Portland State University
Suite 918
1600 SW 4th Avenue
Portland, Oregon 97201
	• Psychosis Risk Syndrome on the Structured Interview for Prodromal Symptoms (SIPS)
	• Individuals who have experienced psychosis within the past 12 months
		• Individualized Placement and Support
		• Multi-Family and Individual Psychoeducation
		• Intensive Team Coordination similar to Assertive Community Treatment
		• Medical Assessment and Treatment
		• Feedback-informed Treatment
		• Dual Diagnosis Treatment (harm reduction using motivational interviewing)
		• Occupational Therapy
		• Cognitive Enhancement Therapy (being piloted)
		• Peer Support
		• Supported Housing
		• Transition Planning
		• Participatory Decision-Making (Statewide Young Adult Leadership Council)
			• Peer Support Specialist
			• Supported Employment Specialist
			• Occupational Therapist
			• Psychiatric Nurse (RN)
				o EASA Program Intake Form
				o EASA Program Education/Outreach Form
				• *For Patients and Families:*
				  o What to Expect During Assessment
				  o Family Guidelines (English / Spanish)
				  o Family Roles (Spanish)
				• *For Professionals:*
				  o EASA Overview
				  o EASA and EASA Center of Excellence Flyer
				  o EASA Referent Brochure (Eng. / Span.)
				  o Advice for Professionals
				  o EASA: Questions and Answers
				  o Cultural Competency Readiness
				  o EASA Adv. Strengths/Needs Assessment
				  o Cultural Considerations
				  o Trauma and Psychosis
				  o Young Adult Identity, Psychosis, & Stigma
				  o Common experience vs. Intended Result
				  o EASA Path to Recovery (Spanish)
				• *Monitoring Fidelity:*
				  o EASA Practice Guidelines
				  o Individual Placement and Support Fidelity
				  o EASA Nurse Monitoring
				  o OT Screening Tool
				• *Outcome Measures:*
				  o EASA Outcome and Review Form
				
				FOR PATIENTS AND FAMILIES:
				• Medication Safety for Families
				• If your Sibling Develops Psychosis
				• Impact of Psychosis on Family Members
				• What Siblings Need
				• Amador's Leap for Effective Communication

The Prevention and Recovery in Early Psychosis (PREP) Model: PREP combines five evidence-based practices to form a strengths-based treatment model for community settings to effectively and stably remit schizophrenia. Length of treatment is based on functional and psychosocial improvement stabilization, with services typically provided up to two years. Click here for a more thorough description	• Ages 14-35
	• Diagnosis of schizophrenia, schizophreniform, schizoaffective disorder, or psychosis not otherwise specified
	• Onset within the past two to five
		• Algorithm-guided Medication Management
		• Cognitive Behavioral Therapy for Psychosis
		• Multi-Family Psychoeducation Groups
			• Program Manager
			• Psychiatrist
			• Nurse Practitioner
			• Licensed or registered Clinical Social Workers, Marriage and Family
				SPECIAL FEATURES:
				• *Outreach and Screening Materials:*
				  o PREP Outreach Webpage
				  o Brochures and Handouts
				  o Informational Videos on PREP
				• *For Patients and Families:*

Program	Eligibility Criteria (May Vary by Treatment Location)	Treatment Components	Team Staffing (May Vary by Treatment Location)	Resources
of this program. Program established in 2006. Contact: Adriana Furuzawa, M.A., C.P.R.P. Tel: 209-644-5054, ext. 2601/ afuruzawa@felton.org http://www.prepwellness.org Felton Institute 1500 Franklin Street San Francisco, CA 94109	years (depending on county) • Residence in county of individual program, some sites focus on Medi-Cal (CA Medicaid) and uninsured.	• Individual Placement and Support • Motivational Interviewing (for Co-Occurring Substance Abuse) • Strengths-based Care Management • Peer Support • Wellness Recovery Action Plan at one site • Peer-led Activity Groups, including Social Skills and Wellness Groups	Therapists, and/or Clinical Psychologists • Individual Placement and Support Worker • Peer Professionals • Family Partners • Administrative Office Staff • Research Assistants	o PREP Intake Process • *For Professionals:* o Felton Institute provides training and consultation for teams to implement the PREP Model, as well as training CBT-p for master's level clinicians and High Yield CBT-p for case managers and other staff. **OUTCOME MEASURES/INSTRUMENTS:** • CBT-p competence is assessed using the Cognitive Therapy Scale – Revised • Quick Scale for the Assessment of Negative Symptoms • Quick Scale for the Assessment of Positive Symptoms • PHQ-9 • GAD-7 • Global Functioning – Role and Social • Working Alliance Inventory • Lack of Judgment and Insight • Medication Adherence Rating Scale • Altman Mania Rating Scale **ADDITIONAL INFORMATION:** • Hardy, K.V., Moore, M., Rose, D., Bennett, R., Jackson-Lane, C., Gause, M., Jackson, A., and Loewy, R. (2011). Filling the implementation gap: A community-academic partnership approach to early intervention in psychosis. *Early Intervention in Psychiatry, 5*(4), 366-374.

Program	Eligibility Criteria (May Vary by Treatment Location)	Treatment Components	Team Staffing (May Vary by Treatment Location)	Resources
The Outreach and Support Intervention Services (OASIS) Program: A team of psychiatrists, psychologists, and social workers use research-based, best-practice clinical skills to help mitigate the effects of early psychosis. There is no time limit on the program; however, persons who develop chronic, disabling psychosis are referred to other treatment programs. Click here for a more thorough description of this program. Contact: Sylvia Saade Tel: 919-962-1401 / sylvia_saade@med.unc.edu http://www.med.unc.edu/psych/cecmh/patient-client-information/oasis Carr Mill Mall 200 N. Greensboro Street, Suite C-6 Carrboro, NC 27510	• Ages 16-36 • Individuals with first episode psychosis within past five years (if not medicated with antipsychotic) • Individuals with first episode psychosis within past three years (if medicated with an antipsychotic) • Located within 90-minute drive of the clinic (most cases)	• Medication Management • Individual Therapy and Recovery Support • Family Therapy and Support Services • Co-Occurring Substance Abuse Treatment Services • Recovery Education • Relapse Prevention • Supported Employment • Supported Education • Peer Support Services • Social Cognition Interaction & Social Skills • Recreational/Social Activity Rehabilitation	• Medical Director • Program Director • Director of Psychological Services • Psychiatrist • Clinical Social Worker • Administrative Assistant	**ADDITIONAL INFORMATION:** • Uzenoff, S.R., Penn, D.L., Graham, K.A., Saade, S., Smith, B.B., & Perkins, D.O. (2012). Evaluation of a multi-element center for early psychosis in the United States. *Social Psychiatry and Psychiatry Epidemiology.*

Early Psychosis Intervention Clinic (EPIC): EPIC is a specialized treatment program offering both outpatient treatment and a consultation service for people who are currently experiencing a psychotic episode or who have recently received a diagnosis of a psychotic disorder.
 	
Contact: Krista Baker
Tel: 410-550-0137 / kbaker1@jhmi.edu
http://www.hopkinsmedicine.org/psychiatry/specialty_areas/schizophrenia/patient_information/treatment_services/early_psychosis.html
Community Psychiatry Program
Johns Hopkins Bayview Medical Center
4940 Eastern Avenue
Baltimore, MD 21224
	• Ages 14-24
	• Individuals with a diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder, delusional disorder, or psychotic disorder, not otherwise specified
	• Diagnosis should have occurred within the past 18 months
		• Medication Management
		• Targeted Case Management
		• Substance Abuse Education and Prevention
		• Multi-Family Support Groups
		• Mobile Treatment
		• Psychiatric Rehabilitation
		• Partial Hospitalization
		• Neuropsychiatric Testing
			• Psychiatrist
			• Licensed Clinician
			• Others not specified
				SPECIAL FEATURES:
				• ***Outreach and Screening Materials:***
				  o EPIC Brochure
				• ***For Professionals:***
				  o Consultation services are available
				
				ADDITIONAL INFORMATION:
				• *CBS Evening News – Jan 31, 2013. "Stigma" of mental illness a setback for patients, society.*
				• Rossbach, M. (2009). Psychiatric and Adolescent Care in "EPIC" Proportions. *Johns Hopkins Bayview Psychiatry.*

Program	Eligibility Criteria (May Vary by Treatment Location)	Treatment Components	Team Staffing (May Vary by Treatment Location)	Resources
Specialized Treatment Early in Psychosis (STEP): STEP is a joint program between the Yale School of Medicine and the Connecticut Mental Health Center. It is a research-based clinic providing comprehensive treatment to individuals in the early course of a psychotic illness. Click here for a more thorough description of this program. Contact: Jessica Pollard, Ph.D. Tel: 203-974-7345 / Jessica.Pollard@yale.edu http://medicine.yale.edu/psychiatry/step/ 34 Park Street New Haven, CT 06519	• Ages 16-35 • In early stages of psychotic illness, with a primary diagnosis of a non-affective psychotic disorder	• Comprehensive evaluation • Medication Management • Cognitive behavioral therapy • Family Focused Therapy • Multi-Family Group Psychoeducation and Support • Supported employment • Social Cognition Interactive Training	• Psychiatrist • Supported Employment Specialist • Primary Clinician • Social Workers • Nurses • Psychologists	**SPECIAL FEATURES:** • *Outreach and Screening Materials:* o How to Seek Treatment **ADDITIONAL RESOURCES:** • List of Publications about the STEP Program
The Cognitive Assessment and Risk Evaluation (CARE) Program: CARE provides outpatient treatment to young adults with a recent diagnosis or newly emerging symptoms of psychosis. [Note: Originally the model specifically targeted individuals at high-risk. It was later expanded to include persons with a first episode of psychosis.] Contact: Kristin Cadenhead, M.D. Tel: 619-543-7745 / kcadenhead@ucsd.edu http://ucsdcareprogram.com 140 Arbor Drive, 4th Floor San Diego, CA 92103	• Ages 12-30 • Individuals experiencing psychosis or with a recent diagnosis • [The broader Program also serves prodromal clients]	• Clinical Consultation • Comprehensive Diagnostic Assessment • Neuropsychological Assessment and Evaluation • Pharmacologic Management Including Alternative/ Complementary Medicine • Intensive Outpatient Tx • Individual Psychotherapy (Cognitive Behavioral, Social Skills) • Group Psychotherapy • Family Therapy • Psychoeducation • Lifestyle Counseling • Mindfulness • Cognitive Remediation • Case Management • Supported Employment/Education	• Psychiatrist • Licensed Psychologist • Others not specified	*None Identified*

Program	Eligibility Criteria (May Vary by Treatment Location)	Treatment Components	Team Staffing (May Vary by Treatment Location)	Resources

*The Calgary Early Psychosis Treatment Services (EPTS) Program: EPTS comprises separate services for first episode psychosis and for those at clinical high risk for developing psychosis. The length of treatment is three years. Click here for a more thorough description of this program.
 	
Contact: Donald Addington
Tel: 403-944-2637 / addingto@ucalgary.ca
Mathison Centre for Research and Education
Department of Psychiatry, Foothills Hospitals
1403 29th Street, NW
Calgary, AB T2N 2T9
Canada
	• Ages 15-55
	• Individuals presenting with a first episode of psychosis who have had less than three months treatment with an adequate dose of antipsychotic
	• Individuals diagnosed with schizophrenia spectrum and other psychotic disorders on the DSM-V
		• Case Management
		• Medication Management
		• Family Psychoeducation
		• Individual Psychoeducation
		• Cognitive Behavioral Therapy
		• Supported Employment
		• Community Living Skills
		• Weight gain prevention
		• Motivational Enhancement or Cognitive Behavioral Therapy for Co-Morbid Substance Use Disorder
			• Case Manager
			• Prescriber
			• Therapist
			• Supported Employment Specialist
			• Team manager (master's level)
			• Others not specified
				SPECIAL FEATURES:
				• *Monitoring Fidelity:*
				  o Team Fidelity Scale (See Appendix)
				• *Outcome Measures/Instruments:*
				  o See Appendix

*The Prevention and Early Intervention Program for Psychoses (PEPP): PEPP is a community-focused mental health program that provides assessment and comprehensive, phase-specific medical and psychosocial treatment for individuals experiencing their first episode of psychosis. The program is structured around a modified assertive case management model. The intensity of the treatment is guided by the patient's needs, the family's needs, and the stage of illness. Length of treatment is two years.
 	
Contact:
Tel: 519-667-6777 / pepp@lhsc.on.ca
http://www.pepp.ca/index.html
London Health Sciences Centre
Victoria Hospital
800 Commissioners Road East, Door 4, Zone A
London, ON N6A 5W9
Canada
	• Youth and young adults (age not specified)
	• Diagnosis of a psychotic disorder
		• Assertive Case Management
		• Cognitive Behavioral Therapy
		• Youth Education and Support Groups
		• Peer Groups
		• Cognitive Skills Training
		• Family Psychoeducation
		• Occupational Therapy
		• Parent Support Group
			• Program Director
			• Case Manager
			• Social Worker
			• Psychiatrist
			• Research Coordinator
			• Possibly others not specified
				SPECIAL FEATURES:
				• *Outreach and Screening Materials:*
				  o PEPP Screening and Assessment Manual
				  o PEPP Early Recognition Brochure
				  o PEPP Symptoms Poster
				• *For Patients and Families:*
				  o PEPP Client and Family Library
				  o Community Events and Educational Seminars
				• *For Professionals:*
				  o PEPP Treatment Manual
				• *Additional Information:*
				  o Early Intervention Research at PEPP

Program	Eligibility Criteria (May Vary by Treatment Location)	Treatment Components	Team Staffing (May Vary by Treatment Location)	Resources
*Early Psychosis Prevention and Intervention Centre (EPPIC): EPPIC is an integrated and comprehensive mental health service aimed at addressing the needs of people with emerging psychotic disorders (including bipolar and schizophrenia-spectrum disorders) in the western and northwestern regions of Melbourne, Australia. EPPIC aims to facilitate early identification and treatment of psychosis and therefore reduce the disruption to the young person's functioning and psychosocial development. An emphasis is placed on: (i) early detection; (ii) acute care during and immediately following a crisis; (iii) and an array of recovery-focused continuing care services to enable the young person to maintain or regain their social/ academic/work trajectory during the critical first 2-5 years following the onset of a psychotic illness. Contact: Jane Edwards Tel: 03 9342 2800 http://eppic.org.au Locked Bag 10 Parkville (mailing) / 35 Poplar Road (physical) Parkville, VIC Australia	• Ages 15-24 • Experiencing first stages of psychosis • [Note: Continuing care provided for 2 to 5 years following FEP onset]	• Home-based assessment and care offered • Cognitively-Oriented Psychotherapy for First Episode Psychosis • Psychoeducation for Client and Families (Individual and Group) • Medication Management • Functional Recovery Activities (Supportive Employment and education and vocation supports) • Case Management • Peer Support • Mobil Outreach • Sub-acute, youth-friendly beds available when needed	• Case Manager • Medical Doctor • Additional Treatment Team Members Based on Need	SPECIAL FEATURES: • *Monitoring Fidelity:* o EPPIC Clinical Guidelines FOR PROFESSIONALS: • Cognitively Oriented Psychotherapy for First-Episode Psychosis: A Practitioners Manual • The Early Diagnosis and Management of Psychosis: A Booklet for General Practitioners MONITORING FIDELITY: • Henry, L., (2004). Psychological intervention in recovery from early psychosis. In Gleeson, J.F.M. & McGorry, P.D. (Eds.) Psychological Intervention in Early Psychosis: A Treatment Handbook. West Sussex: John Wiley & Sons, Ltd. ADDITIONAL INFORMATION: • Hughes, F., Stavely, H., Simpson, R., Goldstone, S., Pennell, K., McGorry, P. At the heart of an early psychosis centre: the core components of the 2014 Early Psychosis Prevention and Intervention Centre model for Australian communities. *Australian Psychiatry*. 2014 May 1;22(3):228-234. [Epub ahead of print]

Program	Eligibility Criteria (May Vary by Treatment Location)	Treatment Components	Team Staffing (May Vary by Treatment Location)	Resources

*Early Psychosis Intervention (EPI) Program: EPI, based in Fraser, British Columbia, is a community-based approach that promotes early detection, educates about psychosis, and directs people that are seeking help to appropriate treatment. There are six clinics offering EPI in British Columbia.
 	
Contact:
Tel: 604-538-4278 (Fraser South Health Location)
http://www.earlypsychosis.ca/
http://www.psychosissucks.ca
15521 Russell Avenue
White Rock, BC V4B 2R4
Canada
	• Ages 13-30
	• Experiencing first episode of psychosis
		• Assessment
		• Care Planning
		• Medication Management
		• Risk Management
		• Physical Health Care
		• Case Management
		• Cognitive Behavioral Therapy
		• Client and Family Psychoeducation
		• Psychosocial Rehabilitation
		• Acute inpatient care
		• Integrated Substance Abuse Treatment
			• Unknown	**SPECIAL FEATURES:**
				• *Outreach and Screening Materials:*
				  o How are you Coping Poster
				  o How are you Coping EPI Brochure
				  o What is Psychosis Flyer
				  o Early Intervention Flyer
				• *For Patients and Families:*
				  o Dealing with Psychosis Toolkit
				  o Booster Buddy Video
				  o Family Coping Booklet
				  o Goal Setting
				  o Lifestyles Outline
				  o Medications Guide
				
				FOR PROFESSIONALS:
				• Standards and Guidelines for Early Psychosis Intervention Programs

*Nova Scotia Early Psychosis Programme (NSEPP): NSEPP is a clinical academic program that provides medical and psychosocial treatments to mitigate the effects of early psychosis.
 	
Contact:
Tel: 902-473-2976 / EarlyPsychosisProgram@cdha.nshealth.ca
http://earlypsychosis.medicine.dal.ca
Abbie J. Lane Memorial Building
5909 Veteran's Memorial Lane
Halifax, NS B3H 2E2
	• Any individual between the ages of 15-35 (residing in the Capital Health District) who is suspected of experiencing or has been diagnosed with a first episode of psychosis, and
	• Has been treated for less than 6 months with an anti-psychotic medication, and
	• At the time of referral has had active, untreated psychosis for less than one year.
		• Medication Management
		• Psychotherapy
		• Crisis Intervention
		• Skills Training
		• Vocational Counseling
		• Care Coordination
		• Individual and Group sessions for Caregivers
		• Psychoeducation
			• Physician (psychiatrist or GP)
			• Social Worker
			• Clinical Nurse
			• Occupational Therapist
			• Educational Coordinator
			• Clinical Affiliate
			• Possibly others, not specified
				SPECIAL FEATURES:
				• *Outreach and Screening Materials:*
				  o Referral Guide
				  o NSEPP Family Information Brochure
				  o The Sooner the Better Education Package
				  o Key Findings Kit
				• *Monitoring Fidelity:*
				  o Service Standards

Program	Eligibility Criteria (May Vary by Treatment Location)	Treatment Components	Team Staffing (May Vary by Treatment Location)	Resources

*Initiative to Reduce the impact of Schizophrenia (IRIS): The Early Intervention in Psychosis IRIS Network supports the promotion of early intervention in psychosis. This network brings together regional leads to share issues and solutions. Length of treatment ranges between two and five years, longer as necessary.
 	
Contact:
Contact Page
http://www.iris-initiative.org.uk/iris/
Program located in the United Kingdom. Contact name and mailing address unavailable.
	• Youth and young adults
	• Individuals experiencing psychotic symptoms related to acute and transient psychotic disorder (no prodrome and short duration of psychotic symptoms for less than two weeks with a clear stressful precipitant), schizophrenia, other non-affective psychoses (e.g., delusional disorder), drug-induced psychosis, bipolar disorder, schizoaffective disorder, psychotic depression, or puerperal psychosis (post-partum mothers).
	• Eligibility Criteria (National Standards as set by the National Institute for Mental Health, England)
		• Medication Management
		• Care coordination
		• Client and Family Psychoeducation
		• Cognitive Behavioral Therapy for Psychosis
		• Supported Education
		• Supported Employment
		• Integrated Dual Diagnosis treatment, if needed
		• Links to physical healthcare and wellness
		• Multi-family groups
			• Program Director
			• Case Manager
			• Therapist
			• Occupational Therapists
			• Possibly others, not specified
				SPECIAL FEATURES:
				• *Outreach and Screening Materials:*
				  o Eligibility Criteria for Accessing EIP Services
				• *For Professionals*
				  o IRIS Guidelines
				  o Early Psychosis Declaration Self-Assessment Toolkit and Instructions
				  o Recovery Guide
				  o IRIS Training Materials for General Practitioners
				  o IRIS Primary Care Overview
				  o Fact Sheet: Early Detection of Psychosis
				  o Fact Sheet: Physical Health Issues of Emerging Psychosis
				  o Fact Sheet: Smoking and Mental Health
				  o Suicide Risk Management in First Episode

*Dublin East Treatment and Early Care Team (DETECT): DETECT aims to provide a service for individuals experiencing first episode psychosis and their families living in specific regions in Ireland. DETECT aims to 1) reduce the duration of untreated psychosis in the catchment area, thereby improving functional and symptomatic outcomes for individuals; 2) to provide patients who have a first episode of psychosis with a rapid, detailed, holistic assessment and offer phase-specific interventions; and 3) to monitor the impact of the service on the duration of untreated psychosis and patient outcomes, and if achieving a positive effect, to oversee the nationwide roll-out of early intervention services.
 	
Contact: Mary Clarke, M.D.
Tel: 353 1 279 1700 / maryclarke@rcsi.ie
http://www.detect.ie
Avila House, Block 5
Blackrock Business Park
Carysfort Avenue
Blackrock County, Dublin
Ireland
	• Ages 17-65
	• Residing within the specific catchment area
	• May have a diagnosis of schizophrenia
	• Has never been medicated for the diagnosis
		• Rapid Comprehensive Assessment
		• Cognitive Behavioral Therapy
		• Occupational Therapy
		• Family Psychoeducation
		• Supported Employment
			Unknown	**SPECIAL FEATURES:**
				• *Outreach and Screening Materials:*
				  o Referral Guide
				• *For Patients and Families:*
				  o Symptoms of Psychosis
				  o Psychosis and DETECT Fact Sheet
				  o The Family and Psychosis: Information about DETECT Carer Education Course
				  o Factsheet: What Can Friends and Family Do?
				• *For Professionals:*
				  o The Irish Psychologist, a leaflet for practitioners
				  o General Practice Guide: Symptoms of Psychosis
				  o General Practice Guide: A Practical Guide to Help Elicit Psychotic Symptoms
				  o Dealing with Psychosis in General Practice
				• *Additional Information*
				  o DETECT Five Year Report

Program	Eligibility Criteria (May Vary by Treatment Location)	Treatment Components	Team Staffing (May Vary by Treatment Location)	Resources
The Bipolar Early Assessment and Management (BEAM) Model: Largely based on the PREP Model, BEAM is modified for individuals with recent onset of bipolar disorder. The program is designed to allow individuals to manage their condition and move towards remission and recovery. Length of treatment is two years, more as necessary. This is a new, emerging program model that adapts the PREP model to bipolar disorder. Click here for a more thorough description of this program. Contact: Adriana Furuzawa, M.A., C.P.R.P. Tel: 209-644-5054, ext. 2601/ afuruzawa@felton.org http://www.prepwellness.org Felton Institute 1500 Franklin Street San Francisco, CA 94109	• Ages 14-34 • Diagnosis of bipolar disorder I • Have experienced between one and three manic episodes	• Medication Management • Cognitive Behavioral Therapy for Bipolar Disorder • Individual Placement and Support • Motivational Interviewing • Strength-based Care Management • Peer-led Activity Groups, Including Social Skills and Wellness Groups	• Program Manager • Psychiatrist • Nurse practitioner • Licensed or registered Clinical Social Workers, Marriage and Family Therapists, and/or Clinical Psychologists • Individual Placement and Support Worker • Peer Professionals • Family Partners • Administrative Office Staff • Research Assistants	**SPECIAL FEATURES:** • ***Outreach and Screening Materials:*** o PREP Outreach Webpage o Brochures and Handouts o Informational Videos on BEAM • ***For Patients and Families:*** o PREP Intake Process • ***For Professionals (Modified for BEAM):*** o PREP provides training and consultation in the following areas: PREP Orientation, Assessment Training (SCID, QSANS/QSAPS), High Yield CBT-p, Intermediate/Advanced CBT-p, Multi-Family Group Training **OUTCOME MEASURES/INSTRUMENTS:** • CBT-p competence is assessed using the Cognitive Therapy Scale – Revised • Quick Scale for the Assessment of Negative Symptoms • Quick Scale for the Assessment of Positive Symptoms • PHQ-9 • GAD-7 • Global Functioning – Role and Social • Working Alliance Inventory • Lack of Judgment and Insight • Medication Adherence Rating Scale • Altman Mania Rating Scale

Program	Eligibility Criteria (May Vary by Treatment Location)	Treatment Components	Team Staffing (May Vary by Treatment Location)	Resources

Youth Partners in Care – Depression Treatment Quality Improvement (YPIC/DTQI): YPIC/DTQI offers depression screening for youth in primary care settings. Care management is a key element of the model. The Care Manager (who may be a psychotherapist, psychologist, social worker, or nurse) works with the referring primary care clinician to evaluate youth and provide treatment/referrals as needed. If a person screens positive for depression, the care manager presents the educational model for understanding depression and treatment options and supports the youth (and/or family) in deciding whether to pursue treatment for depression. Treatment plans are individualized and may include, for example, individual or group Cognitive Behavioral Therapy, antidepressant medication, watchful waiting/monitoring, and specialty consultation. Length of treatment is six months. [Note: for clients choosing to defer treatment, the care manager will still provide periodic telephone follow-up.]
 	
Contact: Joan R. Asarnow, Ph.D.
310-825-0408 / jasarnow@mednet.ucla.edu
UCLA Semel Institute
Department of Psychiatry and Biobehavioral Sciences
760 Westwood Plaza
Los Angeles, CA 90024
	• Ages 13-21, seen in Primary Care Settings, screening positive for depression	• Care Management
		• Individual or Group Cognitive Behavioral Therapy
		• Medication Management
		• Watchful Waiting/Monitoring
		• Specialty Consultation
			• Care Manager (may be a psychotherapist, psychologist, social worker, or nurse)
			• Primary Care Clinician
				FOR PROFESSIONALS:
				• Available resources include (contact the program developer for more information)
				  o Care Manager Guide
				  o Clinician Guide
				  o Individual and Group CBT Manuals
				  o Quick Reference Guide for Clinicians
				  o Patient Education Brochures
				  o Training for CBT is provided (1-3 days)
				  o Training for Clinicians is provided on best practices for evaluating and treating depression in adolescents, development of treatment plans (when to consider medication, psychotherapy/counseling, watchful waiting/monitoring, specialty consultation, and medication management).
				  o Training for Care Managers is provided on how to support primary care providers in patient evaluation, treatment, and monitoring, as well as training in CBT for depression.
				
				ADDITIONAL INFORMATION:
				• Asarnow, J, R., Jaycox, L.H., Duan, N., LaBorde, A.P., Rea, M.M., Murray, P., and Wells, K.B. (2005). Effectiveness of a quality improvement intervention for adolescent depression in primary care clinics: A randomized controlled trial. *Journal of American Medical Association, 293*(3), 311-319.
				• Asarnow, J.R., Jaycox, L.H., Tang, L., Duan, N., LaBorde, A.P., Zeledon, L.R., and Wells, K.B. (2009). Long-term benefits of short-term quality improvement interventions for depressed youths in primary care. *American Journal of Psychiatry, 166*(9), 1002-1110.

Program	Eligibility Criteria (May Vary by Treatment Location)	Treatment Components	Team Staffing (May Vary by Treatment Location)	Resources

Reach Out 4 Teens: Based in western Washington State, *Reach Out 4 Teens* is a developmentally-appropriate, team-based intervention designed to improve the quality of depression treatment in pediatric primary care settings. The program and research represent a partnership between the University of Washington, GroupHealth, and the Children's Hospital of Seattle.
 	
Contact: Laura P. Richardson, M.D., M.P.H.
Tel: 206-884-8245 / laura.richardson@seattlechildrens.org
http://www.reachout4teens.org
2001 8th Avenue, Suite 400
Seattle, WA 98121
	• Ages 13-17 seen in Primary Care who screen positive for depression	• Teen and Parent Psychoeducation and Engagement
		• Teen Choice of Initial Treatment with Parental input
		• Delivery of EBPs in Primary Care Environment:
		   o Medication Management
		   o Cognitive Behavioral Therapy
		• Safety Assessments to Reduce Risk of Self Harm
		• Care Management
		• Weekly Supervision
		• Stepped Care for Adolescents Who are Not Improving
		• Relapse Prevention Planning
			• Not specified	**SPECIAL FEATURES:**
				• *Outreach and Screening Materials:*
				   o Engagement Session Reporting Log
				• *For Patients and Families:*
				   o Planning to Feel Better: A Guide for Depressed Adolescents
				   o How Antidepressant Medications Work
				• *For Professionals:*
				   o DCM Tracking Log
				   o Suicide Protocol
				   o Chart Factsheet
				   o Safety Plan
				   o Patient Progress Report
				   o Relapse Prevention Plan
				
				OUTREACH AND SCREENING MATERIALS:
				• Screening and Assessment Information
				• PHQ-2 Depression Screen
				• PHQ-9 Depression Screen
				• Depressive Symptom Persistence for Re-Screening
				
				INFORMATION ON FIDELITY AND OUTCOMES:
				• Information on the Texas Children's Medication Algorithm Project

*Denotes International Programs

Matrix B: Examples of Individual Evidence-Based Practices

Evidence-Based Practice	Treatment Elements	Provider Requirements	Resources
Medication Management: Helps treatment teams, in collaboration with patients, at mental health agencies develop a systematic plan to make medication management decisions for people with mental illnesses. Source	• Diagnostic Evaluation • Treatment plan, including choice of medication, often using treatment algorithms • Standardized documentation • Cooperation with others involved in patient's treatment • Monitoring progress of treatment.	Requires Physicians, Physician's Assistants, or Nurse Practitioners to prescribe medication.	**FOR PATIENTS AND FAMILIES:** • Mental Illness and Medication Algorithms – A Guide for Mental Health Planning and Advisory Councils: "This guide helps state mental health planning and advisory council members and others advocate for the implementation of medication algorithms to advance the quality of care for persons with mental illness." • Common Ground Shared Decision Making Tool Is a web-based application that helps people prepare to meet with psychiatrists or treatment teams and arrive at the best decisions for treatment and recovery. **FOR PROFESSIONALS:** • SAMHSA MedTEAM EBP Toolkit: This toolkit provides treatment teams at mental health agencies with a systematic plan to ensure they use the latest scientific evidence when making medication management decisions. • Texas Medication Algorithm Project Procedural Manual –Schizophrenia Treatment Algorithms: Provides an overview of treatment algorithms for schizophrenia developed by the Texas Department of Mental Health and Retardation. Related: Texas Children's Medication Algorithm Project – Update from Texas Consensus Conference Panel on Medication Treatment of Childhood Major Depressive Disorder. • Robinson, D., Schooler, N., John, M., Correll, C., Marcy, P., Addington, J., Brunette, M., Estroff, S., Mueser, K., Penn, D., Robinson, J., Rosenheck, R., Severe, J., Goldstein, A., Azrin, S., Heinssen, R., and Kane, J. (2014). Prescription Practices in the Treatment of First Episode Schizophrenia – Data from the National RAISE-ETP Study. *American Journal of Psychiatry,* [Epub ahead of print]. **MONITORING FIDELITY** • Prescriber Fidelity to a Medication Management EBP in the Treatment of Schizophrenia: This article reports prescriber fidelity to MedMAP principles in a public mental health service system." • Evaluating Your Program: Section in SAMHSA's toolkit to help monitor and evaluate the implementation of the MedTEAM EBP.

Evidence-Based Practice	Treatment Elements	Provider Requirements	Resources

Cognitive Behavioral Therapy (CBT): CBT is a type of mental health psychotherapy where the counselor works with patients in a structured manner for a limited number of sessions. CBT helps patients become more aware of negative or inaccurate thinking so they can view their lives more clearly and respond to events more effectively. CBT can be helpful in treating mental disorders or illnesses by helping patients manage symptoms and prevent relapse, manage stress and emotions, improve communication and interpersonal relationships, overcome emotional trauma, cope with medical illnesses, and manage chronic physical symptoms. CBT can be used to treat depression, bipolar disorders, schizophrenia, and other serious mental illnesses. Source	• Based on the cognitive model of emotional response in which modifying thinking modifies emotional or other cognitive responses.
	• Treatment is brief and time-limited, structured and directive;
	• Requires a sound therapeutic relationship and is a collaborative effort between the therapist and the client.
	• Requires active participation by the client in completing homework
		Can be performed by a range of mental health professionals including psychiatrists, psychologists, social workers, nurses or licensed mental health therapists, Educational levels for certification listed below.
		The National Association of Cognitive Behavioral Therapists (NACBT) provides certification in CBT. NACBT offers four certification levels:
		• Diplomate in Cognitive Behavioral Therapy – The highest credential awarded by NACBT. Criteria required for certification (valid for 5 years):
		  ○ Masters or doctoral degree in psychology, counseling, social work, psychiatry, or related field from a regionally accredited university.
		  ○ Ten years of post-graduate experience at providing CBT. This experience must be verified.
		  ○ Three letters of recommendation from mental health professionals who are familiar with the applicant's cognitive behavioral skills.
		  ○ Successful completion of a certification program (all levels) in CBT that is recognized by NACBT, such as Rational Emotive Behavior Therapy, Rational Behavior Therapy, Rational Living Therapy, or Cognitive Therapy.
		• Certified Cognitive Behavioral Therapist – Criteria required for certification include (valid for 5 years):
		  ○ Masters or doctoral degree in psychology, counseling, social work, psychiatry, or related field from a regionally accredited university.
		  ○ Six years of post-graduate experience at providing CBT. This must be verified.
		  ○ Three letters of recommendation from mental health professionals who are familiar with the applicant's cognitive behavioral
			FOR PATIENTS AND FAMILIES:
			• CBT Group Therapy Manual for both Providers and Patients (Spanish Version): This manual provides ground rules for group therapy, a framework of CBT, what to expect in group therapy, and information about how thoughts affect moods. A daily mood scale and "homework" exercises are provided.
			• CBT Open Group Member's Guidebook (Spanish Version): Workbook given to open group members to educate them about CBT group, highlight the connection between thoughts and mood, help patients better identify and manage thoughts (both harmful and helpful).
			• CBT Closed Group Member's Guidebook (Spanish Version): This manual provides ground rules for group therapy, a framework of CBT, what to expect in group therapy, and information about how thoughts affect moods. A daily mood scale and "homework" exercises are provided.
			• CBT Individual Treatment Manual: Client's Guidebook (Spanish Version): Provides an overview of CBT and depression, and highlights the goals of the treatment plan.
			• NAMI CBT Factsheet: Two-page factsheet that provides information about what CBT is, and when it is best used as a form of therapy.
			• Cognitive Therapy Rating Scale: Allows the patient to provide feedback on the quality of the session. Related: Cognitive Therapy Rating Scale Manual.
			
			FOR PROFESSIONALS:
			• A Therapist's Guide to Brief Cognitive Behavioral Therapy: This manual is designed for mental health practitioners looking to establish a solid foundation of CBT skills. Concepts contained in this manual detail the basic steps needed to provide CBT with the intent that users will feel increasingly comfortable conducting CBT. The manual is not designed for advanced CBT practitioners.
			• CBT Group Therapy Manual for both Providers and Patients (Spanish Version): This manual provides ground rules for group therapy, a framework of CBT, what to expect in group therapy, and information about how thoughts affect moods. A daily mood scale and "homework" exercises are provided.
			• CBT Manual for Non-CBT-Trained Professionals: Group Leader Introduction, Open Group Provider Manual (English), Open Group Provider Manual (Spanish)
			• CBT Manual for Closed Group Leaders (Spanish Version): Provides tips to the Group Leader to ensure a successful session, including a list of supplies, goals, and processes.

Evidence-Based Practice	Treatment Elements	Provider Requirements	Resources
		skills. o Successful completion of a primary or introductory certification program in CBT that is recognized by NACBT, such as the Primary Certificate Program in REBT, the Level-One Certification in Rational Behavior Therapy Program, or Level-One Certification in Rational Living Therapy. • Certified Cognitive-Behavioral Group Therapist: Requires Masters-level degree or higher in a mental health profession, and successful completion of the home-study program. • Certified Cognitive-Behavioral Group Facilitator: Requires high school diploma or equivalent, and successful completion of the home-study program.	• Provider's Guidebook – "Activities and Your Mood" – Individual Treatment Version (Spanish Version): Provides tips to the Group Leader to ensure a successful session, including a list of supplies, goals, and processes. A separate "Provider's Introduction" provides background information that explains what depression and CBT are. • How to Become a Cognitive Behavioral Therapist: Information on CBT and how to acquire certification. • Beck Institute for Cognitive Behavioral Therapy: International source for training, therapy, and resources in CBT. • Free CBT Worksheets and Self-Help Resources **MONITORING FIDELITY:** • A Fidelity Coding Guide for a Group Cognitive Behavioral Therapy for Depression: "Provides information on the development and use of fidelity rating tools for... two CBT interventions for clients with co-occurring depression and substance use problems."
Assertive Community Treatment: ACT is a service delivery model whose primary goal is recovery through treatment and rehabilitation. The model provides treatment, rehabilitation, and support services to individuals who are diagnosed with a severe mental illness. ACT teams provide services directly to an individual that are tailored to meet his or her specific needs. Teams have small case loads of only one to 10 individuals. Services are available 24/7. Source	• Services are provided out of the office, are available 24 hours a day and 365 days per year Involving assertive outreach to consumers • Services are provided by a multi-disciplinary team • Treatment plans are individualized • Team members are pro-active in helping consumers • Services are provided long-term; • Emphasis on vocational expectations • Substance abuse services • Psychoeducation • Family support and education; • Helps consumers become less socially isolated and more integrated into their community.	ACT teams consist of case managers, psychiatrists, nurses, team leaders, substance abuse specialists, vocational specialists, and peer specialists.	**FOR PROFESSIONALS:** • Assertive Community Treatment Getting-Started Guide: This manual "helps organizations prepare to implement Assertive Community Treatment." It is organized into seven sections, including FAQs, Answers, Recommended Reading, and Organizational Next Steps. • Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) KIT: Tools to implement ACT, including information in English and Spanish. • Assertive Community Treatment Association (ACTA): ACTA "promotes, develops, and supports high-quality ACT services that improve the lives of people diagnosed with serious and persistent mental illnesses. ACTA also provides training to entities wishing to develop or improve ACT services. **MONITORING FIDELITY:** • ACT Fidelity Scale: Fidelity scale used by the State of Oregon in implementing ACT • Fidelity to the ACT Model: Discusses the issue of fidelity related to ACT. • Dartmouth Fidelity Scale

Evidence-Based Practice	Treatment Elements	Provider Requirements	Resources
Peer Support: Peer support "relies on individuals who live with mental illness to provide peer-to-peer support to others, drawing on their own experiences to promote wellness and recovery. [It is] based on mutual respect and personal responsibility, [and] focuses on wellness and recovery rather than on illness and disability." Source.	• Peer support services rely on peer specialists who "are mental health consumers who have completed specific training that enables them to enhance a person's wellness and recovery by providing peer support." • "Peer services include mutual support groups, peer-run programs and services in traditional mental health agencies provided by peer support specialists."	Peer support can be provided through formal and informal settings. While peers may offer support without undergoing any specific training, peers who provide services in official settings are required to participate in training and certification. A list of Peer Support Training and Certification Programs for each U.S. state is provided in this National Overview, compiled in 2012 by the Depression and Bipolar Support Alliance.	**FOR PATIENTS AND FAMILIES:** • NAMI provides a free Peer-to-Peer educational program, which is recovery focused for adults who "wish to establish and maintain wellness in response to mental health challenges." The ten, two-hour courses provide "critical information and strategies related to living with mental illness." • Mental Health America information about peer services for consumers. • Recovery within Reach, a consumer advocacy organization in Tennessee, provides information about peer support services for consumers. **FOR PROFESSIONALS:** • American Psychiatric Association's Training Module on Peer Supports. • American Psychiatric Association's Network Therapy: Using the Patient's Family and Peer Support for Effective Office Practice • The website for the International Association of Peer Supporters provides access to webinars, a library of resources, and updates on current events related to peer support services. • Pillars of Peer Support Services is an initiative "designed to develop and foster the use of Medicaid funding to support peer support services in state mental health systems of care." The website provides links to the organization's annual summit reports, which provide information about The Role of Peers in Building Self-Management within Mental Health, Addiction and Family/Child Health Settings, Establishing Standards for Excellence, incorporating peer support services into whole health approaches of care, Expanding the Role of Peer Support Services in Mental Health Systems of Care and Recovery, and Transforming Mental Health Systems of Care through Peer Support Services. • National Practice Guidelines developed by the International Association of Peer Supporters.
Cognitive Behavioral Therapy for Psychosis (CBT-p): CBT-p "is an evidence-based treatment for schizophrenia and related disorders which complements pharmacological and other psychological treatments. Its goal is to create a collaborative treatment alliance in which patient and therapist can explore distressing psychotic experiences and the beliefs the patient has formed about these experiences, in an effort to reduce suffering and improve functional capacity in the recovery process." Source	CBT-p treatment consists of engagement strategies, psychoeducation to normalize the experience of psychotic symptoms (and provide alternative perspectives), cognitive therapy, behavioral skills training, and relapse prevention strategies. Source Length of treatment varies between 12 and 20 sessions. Source	Same requirements as Cognitive Behavioral Therapy. Additional specialized training is available.	**FOR PROFESSIONALS:** • Cognitive Behavioural Therapy for Psychotic Symptoms – A Therapist's Manual: This manual presents a clinical guide to implementing CBT for psychosis based on empirical foundations and clinical evaluation. • Social Anxiety in Schizophrenia – Cognitive Behavioural Group Therapy Programme: therapist manual provides practitioners with a structured, yet flexible, approach to treating social anxiety in individuals w/schizophrenia. • The ABCs of Cognitive Behavioral Therapy for Schizophrenia: This article provides a breakdown of the ABC treatment approach, including assessment, engagement, The ABC model provides the patient with a way of organizing confusing experiences. • The Institute of Cognitive Therapy for Psychosis provides "workshops and training for mental health professionals in the treatment of schizophrenia

Evidence-Based Practice	Treatment Elements	Provider Requirements	Resources
			and related disorders." • The Felton Institute/CIBHS CBTp Partnership provides three-day trainings in CBT-p for master's-level clinicians and High Yield CBT-p for case managers and other professionals, followed by fidelity coaching and implementation support. • Training is available through the BeST Center at North East Ohio University.
Cognitive Behavioral Therapy for Bipolar Disorder: Applies the techniques of CBT to help people learn to change harmful or negative thoughts and behaviors. CBT for Bipolar disorder also helps enhance coping strategies and improve communication and problem-solving skills. Source	In addition to CBT, CBT for bipolar disorder also includes psychoeducation to help consumers understand and cope with episodes of mania and depression. Medication management often accompanies CBT for Bipolar Disorder. Source CBT for Bipolar Disorder in pediatrics also focuses on the development of affect regulatory strategies, cognitive restructuring techniques, behavioral management strategies, and social skills training. Source Assessment and re-evaluation of problematic ways of thinking, assertiveness training, treatment of insomnia, mindfulness techniques, social skills training, treatment of underlying anxiety, and problem solving skills. Source	Same requirements as Cognitive Behavioral Therapy.	**FOR PROFESSIONALS:** • Bipolar Disorder – A Group Cognitive Behavioural Therapy Programme: This manual provides a treatment protocol for the therapist with a "comprehensive, detailed and systematic approach to treatment delivery." It provides a notes section for each activity, along with lists of useful materials and potential issues that may arise with group members. Evaluation procedures are also included, as are activities and handouts for participants, including self-monitoring diaries. • Bipolar Affective Disorder - A Cognitive Behavioural Programme for Individual Therapy: This manual provides a treatment protocol for the therapist with a "comprehensive, detailed and systematic approach to treatment delivery." It provides a notes section for each activity, along with lists of useful materials and potential issues to be aware of. Evaluation procedures are also included, as are activities and handouts for participants, including self-monitoring diaries. • Cognitive Behavioural Therapy – Core Information Document: Chapter 4 highlights how CBT can be used to treat bipolar disorder. • CBT for Bipolar Disorder: Provides information on effectively using CBT for Bipolar Disorder when treating pediatric clients. • Cognitive Behavioral Therapy Los Angeles: Provides information on the treatment plan and benefits of CBT for bipolar disorder.
Cognitive Enhancement Therapy (CET): A cognitive rehabilitation training program for adults with chronic or early-course schizophrenia or schizoaffective disorder who are stabilized and maintained on antipsychotic medication and not abusing substances. CET is designed to provide cognitive training to participants to help them with neurocognition and social cognition. Source	Treatment is manual-driven and delivered over a period of 18 months. Elements include: Computer-assisted neurocognitive training; Targeted, performance-based neurocognitive training exercises to improve attention, memory, and problem-solving abilities; Social-cognitive group sessions.	Both neurocognitive training and social-cognitive group sessions are facilitated by masters-level clinicians who have at least two years of experience in the treatment of schizophrenia. Social cognition group sessions require a minimum of two masters-level clinicians who follow comprehensive structured curriculum. CET is designed to be implemented in agency and center-based treatment settings.	**FOR PROFESSIONALS:** • A Provider Manual with CD-ROM and Participant Handouts is available for purchase. • Eack, S.M., Greenwald, D.P., Hogarty, S.S., Cooley, S.J., DiBarry, A.L., Montrose, D.M., et al. (2009). Cognitive Enhancement Therapy for early-course schizophrenia: Effects of a two-year randomized controlled trial. *Psychiatric Services, 60*(11), 1468-1476. • Eack, S.M., Hogarty, G.E., Greenwald, D.P., Hogarty, S.S., and Keshavan, M.S. (2007). Cognitive Enhancement Therapy improves emotional intelligence in early course schizophrenia: Preliminary effects. *Schizophrenia Research, 89*(1-3), 308-311. • Questions about Cognitive Enhancement Therapy can be directed to CET

Evidence-Based Practice	Treatment Elements	Provider Requirements	Resources
			Training, LLC. Tel: 412-206-9418 or Email: questions@cognitiveenhancementtherapy.com
Family Psychoeducation: Family psychoeducation is offered as part of an overall clinical treatment plan for individuals with mental illness to achieve the best possible outcome through the active involvement of family members in treatment and management of the psychiatric illness of their family member. The service aids and supports family members in their reactions to their family members' problems as well as improving the treatment effectiveness for the person with mental illness. Family psychoeducation programs may be either multi-family or single-family focused. Source	Treatment through Family Psychoeducation typically lasts between twelve months and three years. It includes education about serious mental illnesses; informational resources, especially during periods of crises; skills training and ongoing guidance about managing mental illnesses; problem solving; and social and emotional support. Services are provided in three phases: 1) joining sessions, 2) educational workshop, and 3) ongoing family psychoeducation sessions. Source	Family Psychoeducation can be conducted by qualified health educators, nurses, social workers, occupational therapists, psychologists, and clinicians.	**FOR PATIENTS AND FAMILIES:** • Family Psychoeducation vs. Family-to-Family Education Program: Provides basic information about family psychoeducation and family-to-family education for patients and families. **FOR PROFESSIONALS:** • SAMHSA's Family Psychoeducation Toolkit: "Guides public officials in developing family psychoeducation mental health programs." Includes information on training frontline staff. • Family Psychoeducation Training and Certification: A three-day, in-person training on effective tools and techniques (part of the PIER model). • The Family Psychoeducation Workbook: Provides an introduction to approaches to Family Psychoeducation. • Psychoeducation as Evidence-Based Practice – Considerations for Practice, Research, and Policy • Family Psychoeducation Implementation Resource Kit User's Guide: Provides general information on how to implement FPE and make adjustments based on the unique needs of individual communities. • Family Psychoeducation for Schizophrenia: Information on evidence supporting the use of family psychoeducation for treating schizophrenia. • Training is available through the BeST Center at North East Ohio University.
Individual Family Psychoeducational Psychotherapy: Individual Family Psychoeducational Psychotherapy is an individual treatment program for families of children and adolescents (ages 8 to 12) with depressive or bipolar spectrum disorders. Both children and their parents participate in the eight-week program, attending separate group sessions. Source	A manual-based treatment for children aged 8-12 with mood disorders. It is based on a biopsychosocial framework and utilizes CBT and family-systems-based interventions. It is a 20 to 24 session, 50 minute-per-session treatment series that alternates between parents and children attending.	Individual- Family Psychoeducational Therapy can be conducted by qualified health educators, nurses, social workers, occupational therapists and psychologists.	**FOR PROFESSIONALS:** • Individual-Family Psychoeducational Psychotherapy Program Information from the California Evidence-Based Clearing House. Includes information about the evidence-base.
Multi-Family Psychoeducational Psychotherapy: Multi-Family Psychoeducational Therapy (MF-PEP) is similar to Family psychoeducation, but is a group	Multi-Family Psychoeducational Psychotherapy is the group version of Individual Family	Multi-Family Psychoeducational Therapy can be conducted by qualified health educators, nurses, social workers, occupational therapists and	**FOR PROFESSIONALS:** • Multi-Family Psychoeducational Psychotherapy Program Information from the California Evidence-Based Clearing House. Includes information about

Evidence-Based Practice	Treatment Elements	Provider Requirements	Resources
treatment program for families of children and adolescents (ages 8 to 12) with depressive or bipolar spectrum disorders. Both children and their parents participate in the eight-week program, attending separate group sessions. Source	Psychoeducational Psychotherapy, an eight-week program for children ages 8-12. It consists of separate 90-minute group sessions for children and their parents. It has been found somewhat effective in treating children with bipolar disorder. Source	psychologists..	the evidence-base. • Intervention Summary from NREPP
Supported Employment: Supported Employment is an approach to vocational rehabilitation for people with serious mental illnesses. It promotes the belief that everyone with a serious mental illness is capable of working competitively in the community. Source	A comprehensive treatment program that helps consumers find jobs in the open labor market. Supported employment provides ongoing supports as needed. Choices about work are based upon the consumers' preferences, strengths and experience. Supported employment is guided by individuals preferences and places persons in competitive employment settings providing ongoing coaching and support to the individuals and the setting to increase the likelihood of successful work.	Employment specialists should have strong clinical skills, use the model to set performance standards for staff, provide clients with information that allows them to make informed career choices, and help clients achieve job accommodations and overcome cognitive impairments.	**FOR PATIENTS AND FAMILIES:** • University of Illinois at Chicago's Employment Intervention Demonstration Program's Consumer Toolkit: Contains resources and information useful for people with psychiatric disabilities who are looking for practical, user-friendly assistance with their job search. • University of Illinois at Chicago's Center for Mental Health Services and Policy's Seeking Supported Employment – What You Need to Know: This tool helps individuals clarify employment goals and assess the characteristics of supported employment programs for meeting their goals. It is designed for use by the primary consumer, and may help in clarifying employment goals and most effective employment strategies. • Boston University's Center for Psychiatric Rehabilitation's Resources for Potential and Current Workers contains information to assist those with mental illness or in recovery consider, get and retain employment. • A Practical Guide for People with Mental Health Conditions Who Want to Work: Provides an introduction on the challenges mental illnesses present when finding work, and highlights the importance of working and how to overcome barriers. Provides practical guidance on applying for jobs and going through the hiring process. • Facilitator's Manual: A Practical Guide for People with Mental Health Conditions Who Want to Work: Designed as a self-help tool to help persons with mental illness seek and sustain employment. **FOR PROFESSIONALS:** • Boston University Supported Employment Fact Sheet: Provides information on how to develop a successful supported employment site. • Dartmouth Supported Employment Center has been involved in several national demonstrations implementing supported employment programs • Regulatory and Funding Parameters for Peer Specialists in Supporting Employment: Highlights the importance of peer specialists in supporting the competitive employment goals of individuals with a serious mental illness.

Evidence-Based Practice	Treatment Elements	Provider Requirements	Resources
			• Facility Circles of Support: Instruction Manual for Facilitating Circles of Support for People with Mental Illnesses in Supported Employment Settings: A training tool for people learning to implement "Circles of Support in Supported Employment service settings." • Past and Future Career Patterns: A longitudinal portrait of the ways in which those who are often characterized as having an unsuccessful work history relate to the world of competitive employment. • Employment Programming – Addressing Prevailing Barriers to Competitive Work: A policy brief about the barriers persons with psychiatric disabilities face in competitive employment. **FOR EMPLOYERS:** • Boston University's Center for Psychiatric Rehabilitation's Employment Repository contains information and resources to help companies who are considering hiring individuals with psychiatric disabilities and behavioral health conditions, as well as tools to ensure the successful retention and productivity of these employees. General resources list organizations as well as materials concerning legal and other information about employing individuals with any disability, including psychiatric disabilities. Specific resources for psychiatric disabilities include tools, how-to guides, and other information relevant to successfully employing individuals with psychiatric disabilities. **MONITORING FIDELITY:** • Dartmouth Fidelity Measures for Supported Employment

Evidence-Based Practice	Treatment Elements	Provider Requirements	Resources
Motivational Interviewing: Motivational interviewing is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. The operational assumption in motivational interviewing is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change, so that the examination and resolution of ambivalence becomes its key goal. Source	Motivational interviewing typically includes (Source): - Establishing rapport with the client and listening reflectively - Asking open-ended questions to explore the client's own motivations for change - Affirming the client's change-related statements and efforts - Eliciting recognition of the gap between current behavior and desired life goals - Asking permission before providing information or advice - Responding to resistance without direct confrontation - Encouraging client's self-efficacy for change - Developing an action plan to which the client is willing to commit	Direct care service providers from a number of disciplines can be trained to provide the service.	**FOR PROFESSIONALS:** - Motivational Interviewing: Information on Motivational Interviewing from Case Western Reserve University. - Provider Motivational Interviewing Training: Information on training provided by the Iowa Primary Care Association. - The Motivational Interviewing Network of Trainers (MINT): The MINT website provides resources on Motivational Interviewing, including information about the approach, external links, training resources, and recent research. - Motivational Interviewing – Training, Research, Implementation, Practice: Publishes twice-annual issues "containing a variety of formal and informal articles pertaining to research, practice, and training" about Motivational Interviewing.

Evidence-Based Practice	Treatment Elements	Provider Requirements	Resources
Substance Use Assessment and Treatment (Integrated Dual Diagnosis Approaches): Integrated Dual Diagnosis Treatment (IDDT) combines substance abuse and mental health services to improve the lives of people with co-occurring severe mental illness (SMI) and substance abuse disorders. The practice addresses the consumer's unique circumstances to help them achieve sobriety, manage symptoms, and increase their independence through small, incremental changes. IDDT includes medication, psychological, educational, and social treatments, and consumer and family involvement. Source	IDDT is a time-unlimited approach consisting of stage-wise interventions (engagement, persuasion, active treatment, maintenance/relapse prevention) according to the client's stage of treatment or recovery; access to supportive services (e.g., housing, supported employment, family psychoeducation, illness management and recovery, and ACT); outreach; motivational interventions; substance abuse counseling; pharmacological treatment; and health promotion. Source	The multidisciplinary team should be composed of mental health therapist, physician, registered nurse, licensed case manager. A substance abuse specialist with at least two years of experience working with clients with dual disorders works closely with the multidisciplinary team.	**FOR PROFESSIONALS:** • SAMHSA's Toolkit on Integrated Treatment for Co-Occurring Disorders: This toolkit "provides practice principles about integrated treatment for co-occurring disorders… and offers suggestions from successful programs." • IDDT Overview: Provides a brief description of the IDDT model to help with staff recruitment, orientation and education. • Implementing IDDT – A Step-by-Step Guide to Stages of Organizational Change: This booklet provides a brief overview of all the stages of change associated with implementing IDDT, provides a benchmark of current activities, and serves as a record of incremental progress. • Clinical Guide for Integrated Dual Disorder Treatment: • IDDT Stages of Treatment and Treatment Intervention Strategies: Provides a series of treatment options based on client's engagement status. • IDDT Poster – Stages of Change and Treatment: Provides clinicians with a quick guide on using the principles and practices of IDDT. • IDDT Training Events: Training through Case Western Reserve University **MONITORING FIDELITY:** • IDDT Fidelity Scale: Provides an overview of the IDDT Fidelity Scale, and includes a rating sheet and definitions. **OUTCOME MEASURES/INSTRUMENTS:** • IDDT Affiliation Code: Provides information on the data collection initiative in Ohio. Data are collected on consumers enrolled in the state's Multi-Agency Community Services Information System, which allows for the examination of indicators and outcomes to inform policy, community service plans, and service delivery. Related: IDDT Affiliation Code One Pager, Service Utilization SQL Code, General Review SQL Code, **ADDITIONAL INFORMATION:** • A series of audio recordings with Bob Drake, one of the original creators of IDDT, discusses a variety of issues surrounding IDDT, including current research and the effects of merging addiction treatment and mental health.

Evidence-Based Practice	Treatment Elements	Provider Requirements	Resources
PROMISING PRACTICES			
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): "TF-CBT is a components-based psychosocial treatment model that incorporates elements of cognitive behavioral, attachment, humanistic, empowerment, and family therapy models. It includes several core treatment components designed to be provided in a flexible manner to address the unique needs of each child and family. There is strong scientific evidence that this therapy works in treating trauma symptoms in children, adolescents, and their parents. This model was initially developed to address trauma associated with child sexual abuse and has... been adapted for use with children who have experienced a wide array of traumatic experiences, including multiple traumas." Source	• TF-CBT is a short-term treatment, typically provided in 12 to 18 sessions of 50 to 90 minutes, depending on need. • Treatment is usually provided in outpatient mental health facilities, but may be used in inpatient settings, schools, community, and in-home settings. • Joint parent-child sessions are designed to help families practice and use the skills they learn in treatment, and for the child to share their trauma narrative while fostering effective parent-child communication. Source	Same requirements as cognitive behavioral therapy. Additional specialized training is available.	**FOR PATIENTS AND FAMILIES:** • Symptom Tracking Sheet for Parents: This worksheet allows parents to monitor their children's symptoms for each session, based on a severity scale, ranging from "trivial" to "severe." • Symptom Tracking Sheet for Children: This worksheet allows children to evaluate their own symptoms at each session based on a severity scale ranging from "not bad at all/never" to "real bad/a lot." **FOR PROFESSIONALS:** • How to Implement Trauma-Focused Cognitive Behavioral Therapy: This manual, developed by the National Child Traumatic Stress Network, is for therapists, clinical supervisors, program administrators, and other stakeholders who are considering the use of TF-CBT for traumatized children in their communities. • TF-CBT Web, a Web-Based Learning Course for Trauma-Focused Cognitive-Behavioral Therapy: This online learning community provides specific, step-by-step instructions for each component of TF-CBT (Psychoeducation, stress management, affect expression and modulation, cognitive coping, creating the trauma narrative, cognitive processing, behavior management training, parent-child sessions, and evaluation), printable scripts for introducing techniques to clients, and streaming video demonstrations of therapy procedures. Complements other clinical educational materials. • Symptom Tracking Sheet for Clinicians: This worksheet allows clinicians to monitor patients' symptoms for each session, based on a severity scale, ranging from "trivial" to "severe."

Evidence-Based Practice	Treatment Elements	Provider Requirements	Resources
Supported Education: Supported Education helps consumers participate in education programs to achieve recovery goals. Programs help consumers find the right school, locate supports, manage disabilities and education, and use new qualifications to seek employment. Source	There are three models of supported education: • Self-contained classroom: students with similar disabilities take classes together • On-site support: students take regular classes and have access to the services of an education specialist on campus • Mobile support: students take regular classes and have access to the services of an education specialist located at a community mental health center who may meet them either at the mental health center or another off-site location. Source	Preferred Masters-level education (or comparable work experience) with a licensure in mental health counseling, social work, or certified rehabilitation counselor. Source	**FOR PATIENTS AND FAMILIES:** • A Practical Guide for People with Disabilities Who Want to Go to College: A brochure that helps people with disabilities plan their future college experience. **FOR PROFESSIONALS:** • SAMHSA's Supported Employment Toolkit: Contains "information and resources for implementing supported education," including how to get started, deliver services, and evaluate the program. • Sample Job Posting for Supported Education Counselor in New York State • University of Kansas Supported Education Toolkit 3.0: "Provides information and assistance for fidelity reviewers and supported education implementation sites." • Supporting Students – A Model Policy for Colleges and Universities: From the Bazelon Center for Mental Health Law, a set of guiding principles for meeting the needs of students with depression or other mental health conditions.
Open Dialogue: Open Dialogue was developed in the 1980s in Tornio, Finland. This approach "emphasizes listening and collaboration and uses professional knowledge, rather than relying solely on medication and hospitalization." This approach emphasizes "being responsive to the needs of the whole person, instead of trying to eradicate symptoms." Source	There are seven principles to Open Dialogue: • Immediate help: a treatment meeting is held within 24 hours of the crisis • Social network: Clinicians, family members, friends, co-workers, and other important persons are gathered for a joining discussion • Flexibility and mobility: practice is flexible and continuously adaptive, undertaken without preconceptions • Responsibility • Psychological continuity • Tolerance and uncertainty: Uncertainty is embraced by encouraging conversation and avoiding premature conclusions and treatment plans • Dialogue: Patient-centered open and inclusive dialogue. Source	Open Dialogue is provided through meetings between two or more therapists, the patient, and the patient's family and/or support network.	**FOR PATIENTS AND FAMILIES:** • Information on the principles of Open Dialogue and Dialogic Practice **FOR PROFESSIONALS:** • The Institute of Dialogic Practice Provides several year-long training programs for persons new to Open Dialogue, and for persons wishing to train others in Dialogic Practice. **MONITORING FIDELITY:** • The Key Elements of Dialogic Practice in Open Dialogue: Fidelity Criteria (Olson, M., Seikkula, J., & Ziedonis, D., 2014) **ADDITIONAL INFORMATION:** • The Open Dialogue Approach to Acute Psychosis: Its Poetics and Micropolitics (Seikkula, J & Olson, M. E., 2003): Provides information on the development of the model, along with a description of each of the treatment components included in the model. • Dialogical Recovery of Life (Fisher, D., 2012): Article from the National Empowerment Center • Becoming Dialogical: Psychotherapy or a Way of Life? (Seikkula, J., 2011) • Inner and Outer Voices in the Present Moment of Family and Network Therapy (Seikkula, J, 2008)

Selected Additional Resources

Below are additional materials, presentations, websites, and research article citations that may be of interest to entities implementing services for persons in early stages of serious mental illness. In some cases, the listings include live hyperlinks (in blue) for direct access to the resources noted.

Resources Focusing on Early Intervention in Schizophrenia and other Psychotic Illnesses

Federal Agencies:

- **Substance Abuse and Mental Health Services Administration (SAMHSA):** Funding for the Community Mental Health Services Block Grant (MHBG) is administered through SAMHSA's Center for Mental Health Services (CMHS). As such, SAMHSA/CMHS is the Lead Agency for all efforts related to the MHBG five percent set-aside for services for persons in early stages of serious mental disorders. The SAMHSA website includes information and resources for the states about this set aside. Please click here to access this site.

- **Additional Federal Resource:**

  - **National Institute of Mental Health (NIMH) Information on Coordinated Specialty Care:** In an effort to assist states in implementing evidence-based practices to address early psychosis, NIMH has pulled together a set of resources related to *Coordinated Specialty Care (CSC) for First Episode Psychosis* (FEP) that include: an overview document outlining the core components of CSC; manuals for outreach, recruitment and implementation; video vignettes of consumer recovery stories; and links to various program manuals and other resources developed out of NIMH's RAISE Initiative (Recovery After an Initial Schizophrenia Episode). The overview document also includes information related to financing. Click here to access this collection of resources. For additional background information about the RAISE Initiative, please click here. NIMH is in the process of compiling additional resources on the topic of FEP that will be made available online later in 2015. A map of RAISE locations is available in Figure 1 on the next page.

- RAISE Sites
- Two studies
- 22 States
- 36 Sites
- 469 Participants
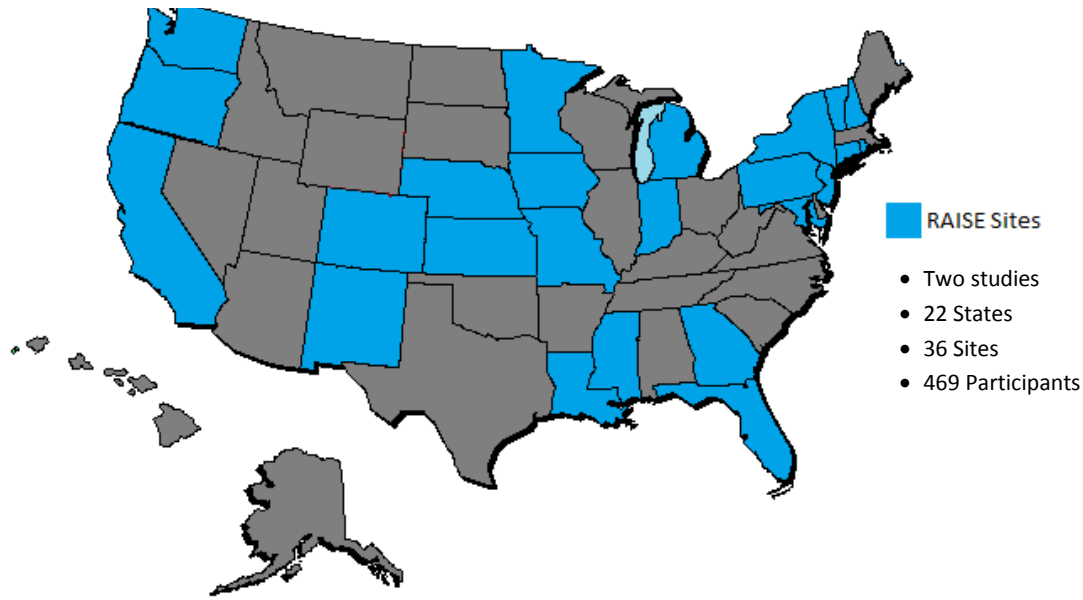
Information on individual programs/clinic sites:

- United States: "Program Directory of Early Psychosis Intervention Programs," was produced by the Foundation for Excellence in Mental Health Care and the EASA Center for Excellence in 2015, and it provides listings and contact information for program sites across the country doing work in the area of early intervention for psychosis (prodromal and first episode).

- International: The International Early Psychosis Association (IEPA) website (http://iepa.org.au/) contains information on work that is happening globally on this topic. In addition to information for patients and families on early psychosis services, there is a section on Early Psychosis Services, that allows users to view lists of clinics within several countries across the globe.

- Characteristics of Early Intervention Programs in the U.S: Dominique A. White, Clinical Psychology Doctoral Student at Indiana University-Purdue University Indianapolis will be publishing the following information in early 2015: "In the current study, we examined program characteristics, clinical services, and treatment population parameters for early intervention programs across the US. A semi-structured telephone interview was conducted with program directors between July 2013 and April 2014. Content analysis was used to identify the presence or absence of 32 evidenced based practices recently recommended for early intervention programs (D.E. Addington, et al., 2013). Frequent client requests were identified and functional definitions of the population served were assessed. A total of 34 eligible programs were identified; 31 (91.2%) program representatives agreed to be interviewed. Findings have the ability to assist researchers and policy-makers in determining best practice models and creating measures of fidelity. This study provides critical feedback on services for the early psychosis population and identifies gaps in services or areas for improvement moving forward."

***Organizations/Networks Addressing Early Psychosis* (not previously referenced in the program matrix)**

- The British Columbia Schizophrenia Society (http://www.bcss.org) is a non-profit organization founded in 1982 by families and friends of people with schizophrenia. They are focused on education, fundraising and advocacy for persons with schizophrenia. On-line materials include:
    - "[Early psychosis: helping your family member](#)."(2006) A resource to help families who have experienced the onset of psychosis in a young person. The booklet aims to help family members and loved ones understand psychosis, how it affects the person, and what family and friends can do to help support the recovery process.
    - "[Fact Sheet: Early Psychosis Intervention](#)."
    - "[Reach out Early: Psychosis Intervention Video](#)"(2005)
    - "[Understanding Mental Illness](#):" A brochure for kids who might know someone experiencing psychosis.
    - "[What's Going on With Me](#)?" Signs and symptoms of psychosis.

- The *University of British Columbia*, Mental Health Evaluation & Community Consultation Unit in the Department of Psychiatry has produced a comprehensive document: ["Early Psychosis: A Guide for Mental Health Clinicians"](#) (2000).

- *The Ontario Ministry of Health and Long-Term Care* has published several documents on the topic of early psychosis, including:
    - "[Program Policy Framework for Early Intervention in Psychosis](#)." (2004) This document establishes Ontario's policy framework, identifying seven key components of early intervention: facilitating access & early intervention, comprehensive assessment, treatment, psychosocial supports, family education and support, research, and public education.
    - "[Early Psychosis Intervention Program Standards](#)". (2011). The Ministry of Health partnered with several organizations to develop this document that expands on the policy framework by organizing Ontario's standards for early psychosis intervention programs.

- The *National Institute for Health and Care Excellence (NICE)* provides national guidance and advice to improve health & social care in England. The body produced a 2014 document, [Psychosis and Schizophrenia in Children and Young People](#) that provides a general overview of principles of care for children and young adults, including a section on presenting first episode psychosis in primary care settings.

- The *Canadian Mental Health Association* (CMHA) is a nationwide volunteer organization that promotes the mental health of all Canadians and supports the resilience and recovery of people experiencing mental illness. The organization offers [A Sibling's Guide to Psychosis: Information, Ideas and Resources](#) (Mulder, S., and Lines, E., 2005) that provides helpful information and support to teens and young adults who have a sibling experiencing first episode psychosis.

Archived Webinars

- **Presentation:** *Components of Coordinated Specialty Care for First Episode Psychosis: Guidance Related to the 5% Set-Aside in the Mental Health Block Grant.* (May 2014)
  - **Presenters:** Paolo del Vecchio, MSW, Director, Center for Mental Health Services; Robert K. Heinssen, PhD, ABPP, Director of NIMH Division of Services and Intervention Research; Lisa Dixon, MD, MPH, Director of the Center for Practice Innovation at the New York State Psychiatric Institute; and Brian Hepburn, MD, Executive Director, Mental Hygiene Administration, Department of Health & Mental Hygiene, Spring Grove Hospital Center
  - **Description:** The presenters provide an overview of the CSC model and highlight the ways in which this this type of programming has been implemented in Maryland and New York.

- **Presentation**: "*Funding Strategies for Early Psychosis Intervention Models*"
  - **Presenter:** Dr. Steven Ronick, CEO, Henderson Behavioral Health (FL)
  - **Description:** Evidence shows that through a comprehensive range of psychiatry plus outreach, prevention, educational, and supportive services, healthcare providers can help reduce the duration of untreated psychosis and improve their clients' outcomes. But how do you secure funding for a program that includes many services that have not traditionally been reimbursed by health insurance plans? What funding streams are available to support the organizational and clinical changes needed? Join us to learn sustainable funding strategies to get your program rolling.

- **Presentation:** *Prep for Success: Lessons Learned in Implementing Models for Early Intervention in Psychosis* (2014)
  - **Description:** There is a growing movement in the U.S. to adopt evidence-based prevention and early intervention models that focus on helping youth and adults who are at high risk for – or experiencing their first episode of – psychosis. By intervening early with a comprehensive range of psychiatric, supportive, and outreach services, community healthcare providers and family support organizations can raise awareness of mental illness in their communities, reduce the duration of untreated psychosis, and ultimately improve individuals' long-term health and functioning. Learn from early adopters who have participated in several national studies of the early intervention/prevention model. Attendees will hear from program directors about the organizational and administrative changes needed for success, along with the key elements of the approach.
  - **Speakers**:
    - Bob Bennett, President & Chief Executive Officer, Family Services Agency of San Francisco, Founder; Felton
    - Robert Heinssen, Ph.D., Director of the Division of Services and Intervention Research, NIMH
    - Darcy Gruttadaro, Director of the Child & Adolescent Action Center, NAMI
    - Ken Duckworth, Medical Director, NAMI

- **Presentation:** *Community Outreach and Prevention as an Element of Early Intervention in Psychosis* (2014)

- o **Description:** Mental illness typically has its onset at a young age – but all too often, individuals, families, teachers, community members, and others are not aware of the risk signs or local resources available to help. How do you reach outside the clinic walls to engage communities in outreach and prevention? What local partnerships should you form, and what kind of public education is needed? Program directors and coalition leaders discuss the key elements of a community outreach program that can strengthen a clinic's ability to provide services to individuals in need. [Note: The outreach information is relevant to entities interested in both serving both prodromal and FEP populations.]
- o **Presenters:** Amy Penkin, Lifeworks Northwest (OR), Tamara Sale, Oregon Early Assessment and Support Alliance (EASA) Mid-Valley Behavioral Care Network and Sarah Lynch or Bill McFarland, PIER (ME)

- • **Presentation:** [First Episodes of Psychosis (FEP) as it pertains to the Mental Health Block Grant: Definition and Prevalence](#) (2014)
  - o **Description:** This webinar will assist states in defining the FEP target population for coordinated specialty care programs, identify where these individuals might be found, and how to engage them early in the course of illness. More specifically it covers:
    - ▪ Definition of FEP –"narrow" versus 'broad" definitions of FEP. For example, a narrow definition might focus on individuals with non-affective psychosis between ages 15-25 who have been ill for 2 years or less. A broader definition could include affective and non-affective psychosis diagnoses, ages 15-30, and perhaps a longer duration of illness, like up to 5 years. The discussion will cover the tradeoffs of the various definitions in terms of prevalence rates and likelihood to benefit from treatment.
    - ▪ Prevalence and incidence of FEP –how to estimate how many persons with FEP already live within the state and how many new cases might appear each year.
    - ▪ How to identify persons with FEP –practical strategies for identifying and diagnosing FEP, the best places to look for these individuals, and the best strategies for developing viable referral pipelines.
  - o **Presenters:** (1) Dr. John Kane, MD, Professor and Chairman of Psychiatry at the Hofstra North Shore-LIJ School of Medicine, and the Principal Investigator for the NIMH-funded RAISE-Early Treatment Program. And (2) Dr. Mary F. Brunette M.D., Associate Professor of Psychiatry at the Geisel School of Medicine at Dartmouth, and a member of the RAISE NAVIGATE research team.

- • **Presentation:** [First Episodes of Psychosis as it Pertains to the Mental Health Block Grant: FEP Modeling Tool](#) (2014)
  - o **Description:** This webinar will assist states in startup planning and implementing Coordinated Specialty Care (CSC) Programs. A sample tool is provided that allows estimates of incidence, differing program sizes and costs, and lengths of stay. Examples illustrate different scenarios from New York and other states.
  - o **Presenter:** Lisa Dixon, M.D., M.P.H. is a Professor of Psychiatry at the Columbia University Medical Center where she directs the Center for Practice Innovations (CPI) at the New York State Psychiatric Institute.

Citations for Selected Peer-Reviewed Articles and Books of Relevance:

<u>Engagement in Care</u>

- Abdel-Baki, A., Ouellet-Plamondon, C., and Malla, A. (2012). Pharmacotherapy challenges in patients with first-episode psychosis. *Journal of Affective Disorders, 138* Suppl: S3-14.
  > "This paper reviews the factors associated with adherence [to therapy] and discusses solutions to optimize engagement, adherence to medication, and treatment in order to prevent relapse."

- Doyle, R., Turner, N., Fanning, F., Brennan, D., Renwick, L., and Lawlor, E. (2014). First-episode psychosis and disengagement from treatment: A systematic review. *Psychiatric Services, 65*(5), 603-611.

  > "This review examines rates and definitions of disengagement among services for first-episode psychosis and identifies the most relevant demographic and clinical predictors of disengagement."

- Kreyenbuhl, J., Nosel, I.R., and Dixon, L.B. (2009). Disengagement from mental health treatment among individuals with schizophrenia and strategies for facilitating connections to care: A review of the literature. *Schizophrenia Bulletin, 35*(4), 696-703.
  > This article "reviews the extent and correlates of dropping out of mental health treatment for individuals with schizophrenia and suggests strategies for facilitating treatment engagement."

<u>Family Involvement</u>

- Addington, J., and Burnett, P. (2009). Working with Families in the Early Stages of Psychosis. In Gleeson, J.F.M. & McGorry, P.D. (Eds.) Psychological Interventions in Early Psychosis: A Treatment Handbook. West Sussex: John Wiley & Sons Ltd.

- Eassom, E., Giacco, D., Dirik, A., and Priebe, S. (2014). Implementing family involvement in the treatment of patients with psychosis: A systematic review of facilitating and hindering factors. *British Medical Journal Open, 4*(10).

  > This study "synthesizes the evidence on implementing family involvement in the treatment of patients with psychosis with a focus on barriers, problems and facilitating factors." It finds that "facilitating the training and ongoing supervision needs of staff are necessary but not sufficient conditions for a consistent involvement of families. Organizational cultures and paradigms can work to limit family involvement, and effective implementation appears to operate via a whole team coordinated effort at every level of the organization, supported by strong leadership."

- Koutra, K., Vgontzas, A.N., Lionis, C., and Triliva, S. (2014). Family functioning in first-episode psychosis: A systematic review of the literature. *Psychiatry Research, 219*(3), 486-496.
  > "The aim of this article is to present a review of the literature focusing on the family environment of FEP patients."

- McNab, C. & Linzen, D. (2009). Family Interventions in Early Psychosis. In Jackson, H.J. & McGorry, P.D. *The Recognition and Management of Early Psychosis: A Preventive Approach*. 2nd Ed. Cambridge: Cambridge University Press.

Children and Adolescents

- Lachman, A. (2014) New developments in diagnosis and treatment update: schizophrenia/first episode psychosis in children and adolescents. *Journal of Child and Adolescent Mental Health, 26*(2), 109-124.
  > This article "highlights new developments, concepts and treatment trends" related to the treatment of early onset schizophrenia (a diagnosis prior to 18 years of age).

- Schimmelmann, B.G., Schmidt, S.J., Carbon, M., Correll, C.U. (2013). Treatment of adolescents with early-onset schizophrenia spectrum disorders: In search of a rational, evidence-informed approach. *Current Opinion in Psychiatry. 26*(2), 219-230.
  > A literature review on the efficacy and tolerability of psychosocial and psychopharmacological interventions in youth with early-onset schizophrenia spectrum disorders (EOS).

- Kranzler, H.N., and Cohen, S.D. (2013). Psychopharmacologic treatment of psychosis in children and adolescents: Efficacy and management. *Child and Adolescent Psychiatric Clinics of North America, 22*, 727-744*.*
  > "The efficacy of antipsychotic use in children and adolescents with psychosis has been shown in an increasing number of randomized controlled trials. Chronic use of second-generation and third-generation antipsychotics has the potential for significant side effects, especially metabolic syndrome. A review of the literature on side effect profiles of antipsychotic medications used in children and adolescents is provided to help clinicians develop treatment plans for their patients."

Cognition

- Zaytseva, Y., Korsakova, N., Agius, M., and Gurovich, I. (2013). Neurocognitive functioning in schizophrenia and during the early phases of psychosis: Targeting cognitive remediation interventions. *BioMed Research International, 2013.*

  > This review highlights "the intervention targets, notably the specific cognitive deficits in at-risk individuals which preceed the transition to psychosis and emphasize the need of additional studies using cognitive remediation approaches in ultra-high risk groups aiming to enhance cognition and therefore mediate functional improvement."

- Aas, M., Dazzan, P., Modelli, V., Melle, I., Murry, R.M., and Pariante, C.M. (2014). A systematic review of cognitive function in first-episode psychosis, including a discussion on childhood trauma, stress, and inflammation. *Social Psychiatry and Psychiatric Epidemiology, 49*(7), 1023-1036.
  > This article provides a systematic review of the literature addressing cognitive functions in first-episode psychosis." It finds that "patients with first episode psychosis present global cognitive impairment compared to healthy controls[, with] the largest effect size observed for verbal memory, followed by executive function, and general IQ." Additional research on this field is needed.

Cognitive Behavioral Treatment

- Alvarez-Jimenez, M., Alcazar-Corcoles, M.A., González-Blanch, C., McGorry, P.D., Gleeson, J.F. (2014). Online, social media and mobile technologies for psychosis treatment: A systematic review on novel user-led interventions. *Schizophrenia Research, 156*(1), 96-106.

  > This article analyzes the results of a "systematic review of peer-reviewed studies examining the usability, acceptability, feasibility, safety or efficacy of user-led, Internet or mobile-based interventions, [including web-based CBT] with at least 80% of participants diagnosed with schizophrenia-spectrum disorders… Results showed that 74-86% of patients used the web-based interventions efficiently, 75-92% perceived them as positive and useful, and 70-86% completed or were engaged with the interventions over the follow-up."

- Burns, A.M.N., Erickson, D.H., Brenner, C.A. (2014). Cognitive-behavioral therapy for medication-resistant psychosis: A meta-analytic review. *Psychiatric Services, 65*(7), 874-880.

  This article provides results of a meta-analysis of CBT's "effectiveness among outpatients with medication-resistant psychosis, both on completion of standardized mean difference corrected for bias." The analysis concludes that "for patients who continue to exhibit symptoms of psychosis despite adequate trials of medication, CBT for psychosis can confer beneficial effects above and beyond the effects of medication."

- **Archived Webinar:** *[Cognitive Behavioral Therapy and Recovery with Persons in Early Stages of Serious Mental Illness](#)* (Spring 2014)
  - **Presenters:** Torrey A. Creed, PhD, Research Assistant Professor of Psychology in Psychiatry and Director of the Beck Initiative; and Aaron T. Beck Psychopathology Research Center, University of Pennsylvania
  - **Description:** Providers often struggle to translate a recovery orientation into specific interventions or to integrate recovery principles with evidence-based practices. This webinar presents a successful integration of recovery principles with cognitive therapy, an evidence-based practice, and its successful implementation in community mental health for individuals with severe mental illness.

Performance Measures

- Donald Addington, M.B.B.S.; Emily McKenzie, M.Sc.; Jean Addington, Ph.D.; Scott Patten, M.D., Ph.D.; Harvey Smith, Ph.D.; Carol Adair, Ph.D.. Performance Measures for Early Psychosis Treatment Services. *Psychiatric Services*, December 2005, vol 56 no 12, p. 1570=1582.
  "This study examined the feasibility of identifying performance measures for early psychosis treatment services and obtaining consensus for these measures. The requirements of the study were that the processes used to identify measures and gain consensus should be comprehensive, be reproducible, and reflect the perspective of multiple stakeholders in Canada. Seventy-three performance measures were identified from the literature review and consultation with experts. The Delphi method reduced the list to 24 measures rated as essential. This approach proved to be both feasible and cost-effective."

Assorted Topics of Interest

- Britvic, D., Maric, N.P., Doknic, M., Pekic, S., Andric, S., Jasovic-Gasic, M., and Popovic, V. (2013). Metabolic issues in psychotic disorders with the focus on first-episode patients: A review. *Psychiatria Danubina, 25*(4), 410-415.
  "This paper critically reviews available data on metabolic problems in patients with psychotic disorders, ranging from genetic to molecular and environmental factors, and highlights the necessity of screening for the early signs of metabolic disturbances, as well as of multidisciplinary assessment of psychiatric and medical conditions from the first psychotic episode."

- Hardy, K., Moore, M., Rose, D. et al. (2011). Filling the implementation gap: A community-academic partnership approach to early intervention in psychosis. *Early Intervention in Psychiatry, 5*, 366-374.
  "The aim of this study was to describe the development of a sustainable community early psychosis program created through an academic-community partnership in the United States to other parties interested in implementing early psychosis services founded upon evidence-based practices within community settings."

- Látalová, K. (2014). Violence and duration of untreated psychosis in first-episode patients. *International Journal of Clinical Practice, 68*(3), 330-335.

  This literature review address prevalence of violence or aggression in the first episode of psychosis, violence or aggression during the periods before and after the initiation of treatment, the duration of untreated psychosis (DUP), and relation between DUP and the level of violence or aggression in first episode psychosis.

- Nordentoft, M., Rasmussen, J.O., Melau, M., Hjorthoj, C.R., and Thorup, A.A.E. (2014). How successful are first episode programs? A review of the evidence for specialized assertive early intervention. *Current Opinion in Psychiatry, 27*(3), 167-172.
  This article investigates the evidence-base for interventions used to treat psychosis within the first five years after the first episode.

- Torres-González, F., Ibanez-Casas, I., Saldivia, S., Xavier, M., and Gómez-Beneyto, M. (2014). Unmet needs in the management of schizophrenia. *Neuropsychiatric Disease and Treatment. 10,* 97-110.
  "This review thoroughly considers several blocks of unmet needs [related to the treatment of schizophrenia and other severe mental disorders]," including health needs, psychosocial and economic needs, clinical staging needs, and integrated evidence-based interventions for improving quality of life.

- Windell, D., and Norman, R. (2013). A qualitative analysis on influences on recovery following a first episode of psychosis. *International Journal of Psychiatry, 59*(5), 493-500.
  "Understanding perceived influences on recovery following a first episode of psychosis could help improve services. Thematic analysis was used to examine important influences on early recovery identified by 30 individuals receiving services in an early intervention program…

Results suggest the importance of assistance with engagement in valued activities and relationships, and provision of messages of worth and hope for recovery."

Resources Focusing on Depression and Bipolar Disorder
(Note: These disorders may or may not also include psychotic symptoms)

Archived Presentations

- *Michael Berk, MD, PhD*, Professor, Senior Principle Research, Professorial Research Fellow at the *University of Melbourne and the Mental Health Research Institute* is a leading scholar in the area of early stage bipolar disorder.
  - o In the archived 60-minute webinar, [Preventing Neuroprogression in Bipolar Disorder by Early Intervention](#), presented in May of 2014, he discusses the progression of the illness, a staged approach to treatment, and strategies for reducing impairment via early intervention.
  - o A 24-minute video [Early Intervention: Neuroprogression and Neuroprotection](#) features Dr. Berk providing an informational lecture on this topic at an Australian Academy of Science conference on Translational Psychiatry.

- **Webinar:** [Understanding and Treating Child and Adolescent Depression](#)
  - o **Presenter:** David, Brent, MD; Dr. Brent, a nationally-recognized expert on depression in young people, is a Professor of Psychiatry, Pediatrics, and Epidemiology at the University of Pittsburgh School of Medicine. He currently directs an NIMH-funded Advanced Center for Interventions and Services Research for Early-Onset Mood and Anxiety Disorders devoted to improving the life course of youth with such disorders.
  - o **Description:** Dr. Brent covers: the presentation, course and causes of depression in young people; the efficacy of different indicated treatments for depression; and the clinical approach to the treatment and prevention of depression in children and adolescents.

- **Webinar:** *[Bipolar Disorders and Intervention Strategies for Optimizing Positive Outcomes](#)*
  - o **Presenters:** Ellen Frank, PhD; Professor of Psychiatry and Psychology at the University of Pittsburgh School of Medicine; and Allen Doederlein, President of the Depression Bipolar Support Alliance
  - o **Description:** Dr. Ellen Frank discusses various facets of bi-polar disorder related to: its manifestation; prevalence; goals of treatment; common psychiatric and physical co-morbidities; its effect on diverse physiological systems; the importance of early identification and intervention; and different types of effective treatment approaches. Dr. Frank is joined by Allen Doederlein, the President of the Depression Bipolar Support Alliance, who discusses the benefits and roles of peer support in helping individuals to recover and live happy and fulfilling

Organizations/Networks Addressing Depression and Bipolar Illness

- The *UCLA Semel Institute for Neuroscience and Human Behavior* does significant work in the area of child/youth depression and bipolar disorder. Their website contains a variety of information on [mood disorders](#) in young people, including a down-loadable [Clinicians Treatment Manual for Family-Focused](#)

Therapy for Early-Onset Youth and Young Adults, as well as slides on "Coping with Bipolar Disorder: Eight Practical Strategies for Enhancing Wellness" geared towards persons who have been newly diagnosed. Another set of slides Depression in Youths: Strategies for Improving Treatment & Patient Outcomes covers information on pediatric depression; findings from the Treatment of Adolescent Depression Study (TADS); the benefits of CBT for treatment and relapse prevention; and information on collaborative care approaches to treating adolescent depression in pediatric primary care settings. There is also a section that includes a listing of Self-Help Resources on Pediatric Bipolar Disorder.

- The *Depression & Bipolar Support Alliance (DBSA)* offers a range of information for: providers, families/friends, advocates, and persons living with depression and bipolar disorders on its website. There is a section that is set up by and for clinicians that includes: videos and podcasts dealing with topics including diagnosis, the course of mood disorders, medication and other treatment options; downloadable brochures that clinicians can offer to clients (including for persons who have just been diagnosed); information on training opportunities; and details on research trials. Of particular note, DBSA is very grounded in a *shared-decision-making* approach to care and includes a section on "working in partnership with your patient" that gives providers information on tools to help empower consumers to identify and track their recovery and wellness goals. Additionally, a "Mental Health Screening Center" allows individuals to take confidential on-line screening for depression, mania, and anxiety. There are excellent resources for consumers that would be of benefit to persons at various stages of illness including: finding a mental health professional, participating in clinical trials, healthy lifestyles, myths and facts, suicide prevention, understanding different types of treatment, dietary supplements, wellness plans, and connections with peer support.

- *The Balanced Mind Parents' Network* focuses on pediatric bipolar disorder and is an excellent virtual resource for caregivers and children that includes a library of helpful materials for families, FAQs, podcasts, webinars, and a family helpline.

- The *Equilibrium Bipolar Foundation* is a non-profit international partnership organization working to advance the understanding and treatment of bipolar disorder. The organization's website includes information on symptoms, causes, and treatment for bipolar illness. There is a section on Treatment Guidelines with listings and links of peer-reviewed articles on clinical practices for the treatment of bipolar, along with a discussion of psychosocial interventions and peer-reviewed articles on various psychosocial interventions. The site also contains various video blogs from experts on topics of relevance to early intervention, such as "Early Warning Signs in Bipolar Disorder" and "Getting a Diagnosis and Access to Treatment for Bipolar Disorder."

- A team in Wales led by staff from *Cardiff University* developed informative on-line resources on bipolar illness, including an "Interactive Education and Information for Family and Carers" and "Diagnosis of Bipolar Disorder: Online Interactive Education Package for Primary Care/Family Practitioners."

- The *Centre for Clinical Interventions* in Western Australia provides a variety of informational resources on its website, including an excellent consumer wellness tool for persons with bipolar, *Keeping Your Balance: Coping with Bipolar Disorder.* This tool includes 8 modules (each with information, worksheets,

and suggested exercises/activities): Overview of Bipolar Disorder; Treatment Options; Self-Monitoring for Relapse Prevention; Behavioural Strategies for Managing and Preventing Depression; Cognitive Strategies for Managing and Preventing Depression; Cognitive Strategies for Preventing Mania; Behavioural Strategies for Preventing Mania; and Coping with Psychosocial Stressors and Self-Management.

- The *Royal Australian and New Zealand College of Psychiatrists* has produced a "Australian and New Zealand Clinical Practice Guidelines for the Treatment of Bipolar Disorder" that is based on a review of the treatment outcome literature (including meta-analyses) and consultation with practitioners and consumers. This guideline provides evidence-based recommendations for the management of bipolar disorder by phase of illness. It specifies the roles of various mood-stabilizing medications, as well as psychological/psychosocial treatments.

General Mental Health Resources of Relevance for First Episode Programs

- *Going to College*: The University of Virginia, with support from the U.S. Dept. of Education, created an on-line resource to promote college success for students with disabilities. The website includes a variety of resources for high school students such as video clips, activities and additional resources that can help teens plan for college. Through several interviews, college students with disabilities from across Virginia provided key information for the site. These video clips offer a way for teens to hear firsthand from students with disabilities who have been successful. There are modules with activities that will help users to explore more about themselves, learn what to expect from college, and considerations and tasks to complete when planning for college.

- *New South Wales Health Department*. "Getting in Early: A framework for early intervention and prevention in mental health for young people in New South Wales." (2001). This report outlines five broad strategies for progressing prevention and early intervention in mental health for young people: 1) developing and coordinating comprehensive programs and services; 2) engaging young people and their families and providing comprehensive assessment and management; 3) developing and implementing prevention programs; 4) educating the community, particularly on depression and related disorders and first onset psychosis in young people; and 5) monitoring quality and effectiveness.

- The *University of Illinois at Chicago, Center for Mental Health Services and Policy:* http://www.psych.uic.edu This national center provides a variety of materials to support recovery-oriented approaches for persons with psychiatric disabilities. Although much of the research and material are specifically developed for persons who have developed a disability related to their illness, many of the approaches may also be helpful for a first episode population. For example, there are various on-line resources related to person-centered care, which can be important elements of a coordinated care approach for persons in early stages of illness. Materials include:

  o "Patient-Centered, Consumer-Directed Mental Health Services." (2014). Examines the concept of patient-centered care and how it is best reflected in mental health services. Uses the IOM

framework from Crossing the Quality Chasm as a guide for improving engagement and full participation in care. This may be especially relevant for engagement of first episode clients.

- o "Person-Centered Planning."(2014) Discusses issues in person-centered planning which may be an important aspect of meaningful engagement in services for persons experiencing a first episode.
- o "Raising Difficult Issues with your Service Provider."(2014) A self-help guide for primary consumers to assist them in discussing a series of issues with service providers that may prove difficult. Provides specific examples of how to start a conversation regarding these topics and maintain a sense of control and autonomy in the consumer's service plan.
- o Self-determination tool. This tool helps individuals assess their goals and current status with aids to help in developing plans for self-determination and self-directed care. These resources may be helpful in the engagement process with persons experiencing a first episode. Includes access to a number of other resources in this area, including "This is Your Life," a life planner.
- o "Self-determination in mental health recovery: Taking back our lives"(Copeland, M.E. 2003). A first-person's account of mental health recovery. This paper discusses her personal perspectives and the perspectives of others on recovery. It includes her personal story of taking back control of her life, breaking down barriers to self-determination, values and ethics that support self-determination, and self-determination facilitators: WRAP and Peer Support.

- Mental Health America (MHA) has an initiative entitled "B4Stage4" designed to foster awareness and early identification/intervention for mental illness. This is an initiative to get people to act by encouraging individuals to take (and to get others to take) confidential screenings, and it offers sample tweets and facebook posts for raising awareness and promoting help-seeking behavior.

- The National Alliance on Mental Illness (NAMI) has an on-line fact sheet, "What Families can do When a Child May Have a Mental Illness" that provides a good overview of information for parents including: behaviors to look out for, explanations of common mental health conditions, tips for getting an accurate diagnosis, how to discuss concerns with one's primary care provider, information on accessing specialty care, and ways to link with other families that have children with mental health problems.

- NAMI also has a set of on-line resources under the heading "It's Time: Innovative Community Approaches to Children's Mental Health: Early Identification and Intervention" that includes video: presentations on school-based mental health services and linkages between mental health and pediatrics, as well as brochures about what families want from primary care in terms of better linkages and support between primary care and mental health.

- The Canadian Mental Health Association is a nationwide volunteer organization that promotes the mental health of all persons and supports the resilience and recovery of people experiencing mental illness. The website can be accessed at http://www.cmha.ca/

- Ireland Shine is an organization that supports people and their families as they face mental illnesses. The website serves as a resource hub that promotes mental health resources, including support groups,

referrals to local mental health centers, peer support specialists, psychosocial rehabilitation, and social activities. The website can be accessed at http://shineonline.ie.

Employment for Persons with Mental Illness
- Boston University. (2009). Barriers to Employment for those with severe mental illness.
    There aren't just economic benefits to employment. For those with severe mental illness, research shows that work can improve self-esteem, lessen psychiatric symptoms, and improve feelings of recovery.
- Burke-Miller, J. (2012). Supported Employment outcomes for transition age youth and young adults. *Psychiatric Rehabilitation Journal, 35*(3), 171-179.
    "The purpose of this analysis is to examine the role of supported employment in achieving employment outcomes for youth and young adults, compared to outcomes for older adults… Among all study participants, youth and young adults had significantly better outcomes in terms of any employment and competitive employment than older adults (age greater than 30 years)."
- Marino, L.A., and Dixon, L.B. (2014). An update on supported employment for people with severe mental illness. *Current Opinion in Psychiatry, 27*(3), 210-215.
    This review examines and summarizes the latest research on Individual Placement and Support, "an effective intervention for helping people with severe mental illness obtain competitive employment."

Other Helpful General Resources

- *Boston University Center for Psychiatric Rehabilitation*: The Center, funded by the National Institute on Disability and Rehabilitation Research and Substance Abuse and Mental Health Services Administration, offers a large variety of materials, including online courses, on a range of topics in psychiatric rehabilitation. Most of these resources were developed for persons with disability related to their illness but are likely to be appropriate for persons with first episode. Materials on "Readiness Preparation" can be helpful in forming relationships with individuals experiencing symptoms of mental illness and in the engagement process. Current research projects involve collaboration with the RAISE initiative as well as work on Cognitive Behavioral Therapy. The BU web site contains an impressive array of materials that can help with the engagement and support process and that have been developed for practitioners, consumers and family members. Information includes:
    - *Resources Related to Reasonable Accommodations for Persons with Mental Health Problems* *A r*esource to help employers, teachers, employees and students address work and school issues, reasonable accommodations, and the Americans with Disabilities Act (ADA). This webpage contains information related to laws, disclosure, and situations related to having a mental illness in the workplace or school setting.
    - Curricula and Workbooks on the Psychiatric Rehabilitation Process These workbooks address a wide range of topics in the rehabilitation process that may be relevant for working with individuals who are experiencing a first episode of psychosis. Of particular relevance may be the materials related to 'readiness preparation' which includes material that is relevant for understanding an individual's perception of their situation and assisting them in the process of addressing their goals through the development of skills and supports. As such, these materials may be helpful in the engagement and relationship development process with consumers experiencing a first episode.   Other relevant material addresses the case management and functional assessment process. Material is also included on self

determination/self directed care and working with families. Most of these curricular materials require purchase of workbooks or other materials.

- o Self-directed on-line courses are also available for a fee. These can be used by practitioners, consumers or family members wishing to acquire skills in a specific area. Employment related courses are available.
- o Boston University Webcasts Webcasts presented by leaders in the field are available on a number of topics related to persons with psychiatric problems. Addressing areas such as:
  - Culturally Competent Rehabilitation Readiness Guide
  - Recovery
  - Health Promotion
  - Integrated Treatment for Persons with Dual Disorder
  - Stages of Change – Prochaska's Transtheoretical Model

- *The Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities:* This center is funded by the National Institute on Disability and Rehabilitation Research (NIDRR) and SAMHSA to conduct research and knowledge translation activities, both to broaden understanding about community integration and to improve opportunities for individuals with psychiatric disabilities to participate more fully in community life. Material is available on a broad range of topics that will be of relevance to individuals who are experiencing their first episode of psychosis. Understanding and effectively responding to these ordinary problems in living that are confounded by illness may be helpful in designing effective first episode programs that meet the wide range of client needs. Specific resources include helpful information on:
  - o The Concept of Community Inclusion
  - o Criminal Justice Issues
  - o Civic Involvement/Voting
  - o Gay and Lesbian Issues
  - o Housing
  - o The Olmstead Act
  - o Peer Support/Consumer Run Services/Peer Specialist
  - o Recreation/Leisure
  - o Relationships/Family and Friends/Intimacy
  - o Self Determination/Advanced Directives/Self Directed Care
  - o Parenting
  - o Physical Wellbeing
  - o Religion and Spirituality
  - o Transportation

Appendix: Profiles for Select Coordinated Specialty Care Programs

Early Diagnosis and Preventive Treatment (EDAPT) & Sacramento EDAPT (SacEDAPT)

Contact Information:

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Located at the Behavioral Health Center

University of California Davis Medical Center

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Sacramento, CA 95817

Please indicate the designated target population for your program, including any information on the diagnoses addressed or other clinical or demographic characteristics.

- EDAPT and SacEDAPT serve youth and young adults, aged 12 to 30 years, and individuals with both non-affective (schizophrenia spectrum – approximately 70% of cases), and affective (e.g., bipolar disorder with psychotic features – approximately 30% of cases) disorders.

How does your program identify, recruit, and/or "screen-in" program participants, including public education/awareness strategies that may be employed?

- EDAPT and SacEDAPT have a wide ranging outreach program to schools, colleges, community mental health, hospitals and emergency rooms and primary care medical clinics. The programs offer a menu of outreach and training activities, ranging from brief talks to half-day workshops for teachers and clinicians on the identification of early psychosis. When referred, clients complete a brief phone screen with the Clinic Coordinator to determine initial eligibility for the program.

What array of treatment services and supports make up your program model (and if the model includes specific evidence-based practices, please list the EBPs)?

- EDAPT and SacEDAPT approach treatment from an integrated family psychoeducation/support and Cognitive-Behavioral Therapy for Psychosis perspective. The programs provide comprehensive assessment (including SCID and SIPS), individual and family Psychoeducation and support, PIER-style multifamily groups, as well as less structured peer support group, family support group, individual and group cognitive behavioral therapy, and supported education and employment. Individuals with substance misuse and abuse are supported through the SacPORT Substance Abuse Management Group.

Are there strategies in place to help ensure fidelity to your program model (and/or to specific EBPs included within that model)? If so, please describe (e.g., what process is in place, what fidelity measures are used, who conducts the fidelity measurement, how frequently is fidelity measured, etc.)?

- Tara Niendam, Ph.D., who trained at UCLA, oversees fidelity through training, ongoing supervision, and measurement of reliability for all assessments. Fidelity is measured after training and twice per year through live observation and supervision.

Are peers involved in your model? IF so, please describe their role.

- EDAPT and SacEDAPT has a 50% time peer advocate who is involved in patient and family engagement, co-leads group, conducts home and community visits, and participates in outreach. The program also

has a 50% time family advocate (parent of individual with lived experience with psychosis) who participates in these activities, and also provides case management and advocacy.

Is the program time-limited, and if so, what is the duration of care?
- Currently, two years. The program is considering increasing this time if funds become available.

What outcome measures does the program use to document impact; are there outcomes that can be shared?
- We examine change in clinical symptom severity using validated instruments, including the Global Functioning Scale: Social and Global Functioning Scale: Role (Cornblatt, et al., 2007), and the CGI-SCH (Haro, 2008; Masand, O'Gorman, & Mandel, 2011), as well as participation in age-appropriate social relationships, rates of employment, graduation, homelessness, hospitalization, and out of home placement. The Columbia Suicide Severity Rating Scale (CSSRS) is used to track suicide ideation and attempts.

Does the program model operate in a single area, or are there clinical sites across the state and/or country? Please indicate the span.
- The program operates in Sacramento County and across a broad region in Northern California. Two affiliated programs, in partnership with a CBO in Napa County and Solano County was recently initiated.

Is your program model affiliated with a university? If so, please name.
- The University of California at Davis.

Please describe the types of training materials that your program has (e.g., for start-up site locations, providers, consumers, families, referral sources, etc.), and please provide a web address/URL if those materials are publicly available.
- UC Davis EDAPT and SacEDAPT Clinic: http://earlypsychosis.ucdavis.edu

To your knowledge, is your model being used by your state (or other states) in conjunction with the five percent Mental Health Block Grant Set-Aside Requirement? If yes, please indicate if/how you are working with the states to meet this new requirement.
- We were awarded Block Grant funds for SacEDAPT to increase our age to 30 and allow individuals with up to two years of psychosis to participate. We anticipate receiving funding in April and will change our criteria at that time.

FIRST Early Identification and Treatment of Psychosis Program
Best Practices in Schizophrenia Treatment (BeST) Center
Department of Psychiatry at Northeast Ohio Medical University

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Best Practices in Schizophrenia Treatment (BeST) Center

Department of Psychiatry at Northeast Ohio Medical University

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Rootstown, OH 44272

Please indicate the designated target population for your program, including any information on the diagnoses addressed or other clinical or demographic characteristics.

- The BeST Center works in partnership with community mental health agencies and other organizations to provide early identification treatment of psychosis services to individuals who have had an initial episode of a psychotic illness. There are currently nine BeST Center-affiliated early identification and treatment of psychosis programs located in different counties throughout Ohio. Each program is called FIRST and is further identified by including the geographic area for the treatment services; for example, FIRST Cuyahoga County (Cleveland) and FIRST Greater Cincinnati Area. By February 1015, there will be 13 various FIRST programs in various urban and rural counties throughout Ohio.

    While each person will be considered for FIRST treatment services on an individual basis, FIRST is most appropriate for individuals who:
    - Are 15-40 years of age;
    - Are diagnosed with schizophrenia, schizoaffective disorder, Schizophreniform disorder or other specified/unspecified schizophrenia spectrum and other psychotic disorder;
    - Have experienced no more than 18 months of psychotic symptoms (treated or untreated);
    - Are willing to consent to participate in at least two treatment modalities that include counseling, psychiatric care, supported employment/education, family Psychoeducation and case management.

    Other considerations – FIRST is not appropriate for individuals:
    - With psychotic symptoms that are known to be caused by the temporary effects of substance abuse or another medical condition
    - With an intellectual disability that impairs their ability to understand all of the treatment components.

How does your program identify, recruit, and/or "screen-in" program participants, including public education/awareness strategies that may be employed?

- Each FIRST program has a team leader. One of the team leader's responsibilities is to coordinate community outreach for FIRST. The BeST Center provides support, training, technical assistance, and materials for outreach. The team leader conducts large and small group face-to-face meetings with individuals in the community to create and maintain a referral network. Inpatient psychiatry units, psychiatric emergency services, community mental health agencies, advocacy organizations, schools,

colleges and universities, law enforcement personnel, judges and court personnel, primary care services, social service agencies, homeless shelters and others are among the targets for FIRST outreach.

The BeST Center also maintains a master contact list of FIRST referral sources for all FIRST programs so that these individuals can receive periodic newsletters and updates.

Each FIRST team also has a dedicated phone line for referrals to the program. The FIRST team leader contacts the prospective individual and his or her family or significant other within 24 hours of expressing interest in FIRST or receiving a call from the referral source. The team leader will conduct a phone screening to assess if the individual is an appropriate candidate for FIRST treatment services. Upon completion of the phone screening, if the individual appears to be appropriate for FIRST, he or she will be scheduled for a mental health assessment with the team leader within 72 hours. If the team leader feels the individual is eligible for FIRST, he or she will schedule an appointment for the individual with the FIRST team psychiatrist within 14 days. The team psychiatrist ultimately determines a client's eligibility for FIRST.

If the individual is appropriate for FIRST, the team leader will work with him or her to choose at least two FIRST services: psychiatric care, individual counseling, supported employment/education, family Psychoeducation and case management. The team leader then schedules appointments with the team members who provide the FIRST services that the individual selects.

If, at any point in this process, the team leader or the psychiatrist do not believe that the individual is eligible for FIRST, the team leader will make arrangements for him or her to receive the treatment services that are most appropriate for him or her.

What array of treatment services and supports make up your program model (and if the model includes specific evidence-based practices, please list the EBPs)?
- FIRST offers comprehensive, integrated treatment delivered by a six-person team that includes a team leader (who also provides family psychoeducation), a psychiatrist, two counselors, a supported employment/education specialist and a case manager. FIRST clients are required to participate in at least two of the following FIRST treatment modalities: individual counseling, psychiatric care, supported employment/education, family psychoeducation and case management. Many clients participate in more than two modalities, but only two are required. Family psychoeducation and supported employment are evidence-based practices within the program, but we do not assess for full fidelity.

Many of the services used in first-episode programs were originally developed for individuals with longer-term conditions and related disability (e.g., ACT, Supported Housing). What modifications have you made to these programs, if any, to better accommodate the needs of first episode clients?
- The BeST Center's FIRST program has made modifications to the following treatment components to better accommodate the needs of first episode psychosis clients:
  - Family Psychoeducation: The FIRST Family Psychoeducation component is based on Behavioral Family Therapy, but it is offered in an abbreviated format.
  - Cognitive Behavioral Therapy for Psychosis: The BeST Center and its international collaborators have developed Cognitive Behavioral techniques for psychosis (CBt-p)I, techniques derived from Cognitive Behavioral Therapy can be used by both licensed and non-licensed staff, including case managers, to help clients cope more effectively with illness symptoms. The BeST Center

provides training and ongoing clinical supervision in CBt-p to all members of the FIRST treatment teams.

- o Illness Management and Recovery: The individual counseling component of the FIRST program is based on Illness Management and Recovery; all FIRST clients complete the five core modules of a manualized treatment program with a treatment team member. Clients can elect to complete additional modules focused on specific topics based on needs and preferences.
- o Prescribing Patterns: Decisions about medication are made using a shared decision-making model, and the medications offered have been determined to be the safest and most effective for individuals experiencing an initial episode of a psychotic illness based on an extensive literature review.
- o Supported Employment: FIRST Supported Employment adheres to the basic principles of the evidence-based practice, but is offered in a somewhat abbreviated version.

Are there strategies in place to help ensure fidelity to your program model (and/or to specific EBPs included within that model)? If so, please describe (e.g., what process is in place, what fidelity measures are used, who conducts the fidelity measurement, how frequently is fidelity measured, etc.)?

- While, to date, we do not have specific fidelity measures in place for the FIRST program, the BeST Center provides the services of a BeST Center consultant/trainer who attends all treatment team and supervision meetings and assists the teams in implementing the FIRST program model. FIRST is also a manualized treatment program; the BeST Center provides a comprehensive training program for each team member, and a manual for the specific treatment services that he or she provides.

Are peers involved in your model? IF so, please describe their role.

- Peers do not have a specific role in the FIRST program model at this time (N.B. In Ohio, peer support is not a Medicaid-covered service). We are considering adding peer support to the FIRST model in the future, and treatment teams/clients are free to utilize peers as available.

Is the program time-limited, and if so, what is the duration of care?

- The anticipated duration of care in FIRST specialty services is three to five years; however, the program is not time-limited, and actual duration of care is based on clients' needs and preferences. The duration of treatment follows the recommendations of the RAISE program.

What outcome measures does the program use to document impact; are there outcomes that can be shared?

- Clients enrolled in FIRST treatment services undergo assessment at baseline and every six months for as long as they are enrolled in the FIRST program. Assessments include the Clinician-Rated Dimensions of Psychosis Symptom Severity, which is administered by the FIRST team psychiatrist, and an Outcome Review Form, which is administered by the FIRST team leader. The Outcome Review Form measures: current living situation, education, employment status, legal involvement, hospitalization, frequency of substance use, medical services received, relationship with family and significant others, medication compliance and other outcomes. These data are collected for all FIRST programs throughout Ohio and analyzed by the BeST Center. They are also shared with the FIRST teams and their respective agency leadership to inform quality improvement.

   Initial clinical outcomes for individuals in FIRST, although early, are promising: the vast majority of individuals are either working and/or pursuing educational goals full-time or part-time; the re-

hospitalization rate is low, and clients report getting along with family members much or most of the time. We also gather service and fiscal data on each program; costs compare very favorably to other states' experiences with early psychosis programs.

Does the program model operate in a single area, or are there clinical sites across the state and/or country? Please indicate the span.

- There are currently FIRST programs in the following Ohio counties: Summit (Akron), Portage, Mahoning, Trumbull, Cuyahoga (Cleveland), Lucas (Toledo), Greater Cincinnati Area (Clermont and Hamilton Counties), and Stark (Canton). By February 2015, FIRST programs will also be available in Wood, Allen, Auglaize, and Hardin Counties.

Is your program model affiliated with a university? If so, please name.

- The FIRST Early Identification and Treatment of Psychosis programs are sponsored by and affiliated with the Department of Psychiatry at the Northeast Ohio Medical University in Rootstown, Ohio.

Please describe the types of training materials that your program has (e.g., for start-up site locations, providers, consumers, families, referral sources, etc.), and please provide a web address/URL if those materials are publicly available.

- The BeST Center provides a comprehensive, intensive training program for all members of the FIRST team. Training includes an overview of the FIRST program and a two-day training workshop in Cognitive Behavioral Techniques for Psychosis (CBT-p), one of the clinical techniques used by the FIRST treatment team.

  In addition, each member of the team receives a training manual: Psychiatry Manual, Individual Counseling Manual, Supported Employment/Education and Case Management Manual, or Family Psychoeducation Manual. The team leader and agency administrators also receive a FIRST Procedure Manual.

  In addition to this initial training, the BeST Center also provides ongoing expert consultation and training, including the services of BeST Center experts for early identification and treatment of psychosis programs, CBT-p, family psychoeducation and outreach and dissemination.

To your knowledge, is your model being used by your state (or other states) in conjunction with the five percent Mental Health Block Grant Set-Aside Requirement? If yes, please indicate if/how you are working with the states to meet this new requirement.

- No response.

RAISE Connection Model
At the University of Maryland Medical Center and School of Medicine

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http://www.connectionprogram.org

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110 South Paca Street

Baltimore, MD 21201

Please indicate the designated target population for your program, including any information on the diagnoses addressed or other clinical or demographic characteristics.

- Criteria for admission to RAISE include:
  - o Ages 15 to 35 (although it was agreed in the early intervention program meeting that this would be 15 to 30; in reality if a person is admitted at 30 they would be eligible for continued services for two years, so given the presentation, the program is a bit flexible around age).
  - o Diagnosis of schizophrenia, schizoaffective disorder, Schizophreniform, delusional disorder, or psychosis not otherwise specified (NOS).
  - o Duration of psychotic symptoms greater than one month and less than two years, or approval through a case review process by the Medical Director of the RAISE Program.
  - o Ability to provide informed consent to receive services.
  - o Anticipated ability to participate in the program for at least one year.
- Criteria that render a person ineligible to receive services:
  - o Other diagnoses associated with psychosis, including substance-induced psychotic disorder, psychotic affective disorder (psychosis associated with major depression or mania), psychotic disorder associated with a general medical condition or mental retardation.
  - o Substance-induced psychosis
  - o Mental retardation
  - o Pre-existing developmental disorders (e.g., PDD and autism)

How does your program identify, recruit, and/or "screen-in" program participants, including public education/awareness strategies that may be employed?

- Referrals into our program are done in a variety of ways, including our team leader reaching out to adolescent units (in person and by phone) in Baltimore City and County where teens are often seen early in their illness; taking phone referrals from providers and doing a telephone screen; and also by circulating a referral form to hospitals and programs that commonly seek our services.
- Our umbrella program, the Maryland Early Intervention Program, employs public education and awareness strategies. There is a well-organized, state-wide education and training initiative to communicate information about early onset psychosis, education about recognition and referral process, consultation services to providers state-wide, and training to providers on how to set up an early intervention program.

What array of treatment services and supports make up your program model (and if the model includes specific evidence-based practices, please list the EBPs)?

- Services include:
  - Family and Client Psychoeducation
  - Comprehensive Multidisciplinary Psychiatric and Psychosocial Evaluation
  - Evidence-based Supported Employment and Supported Education
  - Medication Management
  - Substance Abuse Treatment
  - Individual Psychotherapy
  - Group Therapy
  - Multidisciplinary Team Approach with Family Involvement
  - Recovery-based Approach Based on Client and Family Goals
  - Safety Planning for Family and Clients
  - Outreach Services with Connection to Appropriate Community Resources

Are there strategies in place to help ensure fidelity to your program model (and/or to specific EBPs included within that model)? If so, please describe (e.g., what process is in place, what fidelity measures are used, who conducts the fidelity measurement, how frequently is fidelity measured, etc.)?

- Fidelity is measured by adherence to specific programmatic mandates such as:
  - All families have a home visit as part of the initial intake to the program.
  - Physician visits are weekly for the first quarter, then spaced out.
  - There are mandated psychoeducation sessions, multi-family groups, and client safety plans. all implemented from entry into the program and forward.
  - There are medication algorithms that physicians follow to avoid over-use of meds or use of those that are particularly problematic in this population.
  - There are quarterly symptom checklists and recovery goal monitoring that are completed and entered into the RedCap database for tracking, etc.
  - Team meetings with physicians, employment/education specialists, recovery coaches, and clients are mandatory, and families are encouraged to attend these sessions.

Are peers involved in your model? IF so, please describe their role.

- We do have a peer support group every Friday where all participants in the program can come and explore with each other important topics that they identify. These are often very appropriate developmentally-based discussions on relationships, work and finishing their education or attending college.

Is the program time-limited, and if so, what is the duration of care?

- This is a critical time intervention, lasting two years.

What outcome measures does the program use to document impact; are there outcomes that can be shared?

- We are focusing on functional outcomes connected to the recovery goals that were set by the client on admission and during treatment. Progress on the client's recovery goals fits into one or more of the following categories:
  - Social (relationships, communication, etc.)
  - Educational goals
  - Employment goals
  - Substance use goals (or reduction in)

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Data are collected quarterly on positive, negative, and depressive symptoms, as well as quarterly assessments of movement disorders. We also do quarterly assessments of side effects.

Does the program model operate in a single area, or are there clinical sites across the state and/or country? Please indicate the span.

- The program has a single site located in Baltimore City, but takes referrals across central Maryland. We are in the process of assisting two additional sites to open in the state.

Is your program model affiliated with a university? If so, please name.

- The University of Maryland School of Medicine and Medical Center

Please describe the types of training materials that your program has (e.g., for start-up site locations, providers, consumers, families, referral sources, etc.), and please provide a web address/URL if those materials are publicly available.

- As an outcome of the RAISE Research Project, we have well-developed program manuals for each of the team members and for the entire program. Team Leader, Recovery Coach, Employment and Education Specialist, and Psychiatrist. For medication management, we have well-defined protocols for medication selection in-line with evidence-based treatments. We follow the SAMHSA Supported Employment model.

To your knowledge, is your model being used by your state (or other states) in conjunction with the five percent Mental Health Block Grant Set-Aside Requirement? If yes, please indicate if/how you are working with the states to meet this new requirement.

- The 5% mental health block grant set-aside will be used to further expand RAISE through funding to support the Early Intervention Program, currently under development in Maryland. The Maryland Early Intervention Program (EIP) will be a specialized program with expertise in the early identification, evaluation, and comprehensive psychiatric treatment of adolescents and young adults with psychotic disorders. The EIP will be comprised of three components: 1) Outreach and Education Services, 2) Clinical Services; and 3) Regional Early Intervention Learning Collaborative Teams. Research will be integrated into each of these components and will focus on using existing/new objective methods for early detection and prediction of disease emergence, progress or recovery. These tools will then be used to guide intervention refinement to enhance efficacy and effectiveness.

  The 5% mental health block grant set-aside will primarily address the second component of EIP, Clinical Services. The funding will support infrastructure and management, as well as data collection/evaluation, of two new RAISE Connection-like Early Intervention Teams under the EIP, serving the same population as the RAISE Connection program described above. Although some of the services provided by the new teams will be reimbursable, a considerable number of them will not. Additionally, time spent in training, and more importantly, in outreach/education to the broader community are not reimbursable. The 5% mental health block grant funding will provide the critical support needed to structure the teams to maximally provide the appropriate support to those with early psychoses, as well as to provide outreach and education, in order to identify as many in need of these services as possible. The Team roles include:
  - Team Leader – overall coordination of services, individual therapy, case management, crisis intervention, information gathering, safety planning, outreach/education.

- o Recovery Coach – Social Skills training, weekly participation group, monthly family group, school coordination, outreach/education.
- o Employment/Education Specialist – Job development, addressing work and school-related goals/problems, outreach/education.
- o Psychiatrist – Prescribing, shared decision making, education.

NAVIGATE RAISE Early Treatment Program (ETP)

Contact Information:

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- Susan Gingerich
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Please indicate the designated target population for your program, including any information on the diagnoses addressed or other clinical or demographic characteristics.

- The NAVIGATE Program was developed to treat individuals aged 15 to 40 with diagnoses of Schizphreniform disorder, schizoaffective disorder, schizophrenia, brief psychotic disorder, and psychotic disorder not otherwise specified. The NAVIGATE Program is intended for both individuals whose acute psychotic symptoms have remitted or been stabilized, as well as those who continue to have severe symptoms related to their first episode. The NAVIGATE trial required individuals to be in or recovering from their first episode of psychosis and have less than six months of cumulative exposure to antipsychotic treatment. NAVIGATE was developed for the RAISE-ETP study. Studies require fixed inclusion and exclusion criteria. We have no data about how effective NAVIGATE would be with related patient groups (e.g., patients with one episode of psychosis but more than six months of prior treatment with antipsychotics).

How does your program identify, recruit, and/or "screen-in" program participants, including public education/awareness strategies that may be employed?

- The NAVIGATE treatment team includes a site project director who is responsible for recruiting participants into the program. The project director identifies and develops relationship with local referral sources who have contact with potential participants. Examples of local referral sources include inpatient units, emergency rooms, mobile crisis programs, NAMI, schools, churches, etc. The project director is responsible for educating the referral source about the NAVIGATE program and developing a process for referring participants.

  The project director meets with staff (administrators, doctors, nurses, social workers, therapists, and case managers) at the referral sources to inform them about the NAVIGATE program and the services it offers to participants. The project director identifies a primary point of contact at each referral source with whom they will have regular contact to discuss potential participants that have been identified. Where possible, the referral source assists the project director in making initial contact with the potential participant.

We also have NAVIGATE information available directly to the public on public website and other media. We do receive direct inquiries (often from family members) about our program, but the number of potential participants identified by these efforts is much less than from our professional referral efforts.

What array of treatment services and supports make up your program model (and if the model includes specific evidence-based practices, please list the EBPs)?

- The NAVIGATE program is designed to be staffed by a team of mental health professionals who work together to provide and coordinate the interventions. The components of the program include: Individual Family Therapy, Individual Resiliency Training (IRT), Supported Employment and Education (SEE), and Individual Medication Management. The team consists of a project director, individual therapists, supported employment and education specialist, and a prescriber. The team is led by the project director who is responsible for recruitment of individuals into the NAVIGATE program, coordinates and leads the team; supervises the IRT clinicians, and SEE specialist, and usually provides the Family Program.
The Family Program focuses primarily on family members or significant others who have regular face-to-face contact with the client. The role of family members in providing social support, and their potential importance as allies in treatment, is explored with clients early on in the NAVIGATE program, and with the client's permission, families are contacted and engaged in the Family Program as soon as possible. Family sessions are provided to individual families, including the client and involved family members or significant other persons, although if the client prefers, sessions can also be provided without him or her. Sessions can occur at the clinic, home, or some combination thereof.

  The IRT program was modeled after two other programs aimed at improving illness self-management and psychosocial functioning, the Illness Management and Recovery (IMR) program and the Graduated Recovery from Initial Psychosis (GRIP) program. IRT is provided by a clinician, usually on a weekly or bi-weekly basis at the beginning of NAVIGATE. Sessions can be conducted at either the clinic or in the community and last approximately an hour, although length can be adapted to the individual client. The focus is on helping clients achieve personal goals through developing their own personal resiliency, and learning information and skills about how to manage their illness and improve functioning.

  The SEE program is based on the principles of IPS supported employment, broadened to address education, and adapted for people with a recent first episode psychosis (FEP). At the beginning of NAVIGATE, all clients meet with the SEE specialist to discuss how SEE services help people to achieve their potential work or educational goals. SEE is provided to those clients who want to work, attend school, or both, regardless of their symptoms, with most services provided in the community (e.g., client's home, coffee shops, walking streets, visiting educational programs or potential employers). For clients who are not initially interested in work or school, the other NAVIGATE team members remain alert to opportunities to instill hope and motivation to work or attend school, at which point they can begin meeting with the SEE specialist again.

  Individualized medication treatment in NAVIGATE incorporates research findings about the specialized medication approaches needed for people with early phase schizophrenia-spectrum disorders, including the use of the lowest medication dose possible. Pharmacological treatment is tailored to individual client's needs and preferences, including clients who choose to stop taking medication. Clients who want to discontinue their medication continue to participate in the NAVIGATE program, including seeing

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the prescriber on a regular basis if they are willing, in order to maintain a working alliance with the team, and to facilitate the resumption of medication should the client choose. Medication treatment used COMPASS, a computer clinical decision making tool using a measurement-based care approach that was developed for NAVIGATE and is available to NAVIGATE prescribers and clients on a secure website. COMPASS facilitates client-prescriber communication through direct client input of information about symptoms, side effects, treatment preferences, and other issues into the system. These data then guide prescribers in their sessions with clients. COMPASS also provides guidance about evidence-based medication strategies that inform client-prescriber decision making about medication treatment.

Manuals for all treatment components, including a team member's guide, are available at http://www.navigateconsultants.org.

Are there strategies in place to help ensure fidelity to your program model (and/or to specific EBPs included within that model)? If so, please describe (e.g., what process is in place, what fidelity measures are used, who conducts the fidelity measurement, how frequently is fidelity measured, etc.)?

- The NAVIGATE program assesses fidelity for each treatment component and certifies the clinicians providing the services. Fidelity assessments and certifications are completed by the national trainers and certification requirements vary between treatment components. For each prescriber, certification is received upon completing a series of webinar training sessions. IRT and family clinicians are required to submit audiotapes of sessions with participants. Certification is received after completion of required training and receiving a satisfactory or above-grade rating on a specified number of recorded sessions. For SEE, a fidelity measure was developed to rate the overall program implementation rather than individual certification of the specialists. To maintain fidelity to the program, all treatment components hold regular consultation calls with clinicians to discuss their NAVIGATE patients and provide guidance on implementation. The COMPASS system records all medication prescriptions in real-time to the study database. This provides the ability to make detailed longitudinal assessment of adherence to NAVIGATE treatment guidelines by NAVIGATE prescribers.

Are peers involved in your model? IF so, please describe their role.

- Peer-based services were not part of the model, but peer services are compatible with the NAVIGATE model, and if already available at sites, they can be added to the NAVIGATE program.

Is the program time-limited, and if so, what is the duration of care?

- The program for the RAISE-ETP study was time-limited (two years of treatment), but outside of a study context, NAVIGATE treatment duration can be more flexible. On average, individuals and families usually work closely (e.g., weekly) with one or more members of the team for six to 12 months, followed by less frequent services (e.g., monthly) for 12 to 18 months. After two years, the team, the individual, and his or her family usually work together to decide on the next best steps to continue the individual's recovery. Some individuals stay with the NAVIGATE team at the same levels or a less intensive basis (e.g., monthly or every two month check in), some transfer treatment to a non-NAVIGATE team, and some may discontinue treatment with the understanding that they may return in the future.

What outcome measures does the program use to document impact; are there outcomes that can be shared?

- The NAVIGATE trial collected data on an individual's physical and emotional health. Individuals in the NAVIGATE trial completed questionnaires that assessed their utilization of inpatient and outpatient services, attitudes toward medication, and overall health. In addition, every six months, individuals were assessed using a blinded, central rater connected via two-way video to measure Quality of Life using the Heinrich-Carpenter Quality of Life Scale (QLS), symptom assessment using the Positive and Negative Syndrome Scale (PANSS), and the Calgary Depression Scale for Schizophrenia (CDSS), and overall illness severity using the Clinical Global Impressions – Severity Scale (CGI-S). The national team will provide consultation to teams implementing the NAVIGATE program on which measures are feasible for collection within a clinical context.

Does the program model operate in a single area, or are there clinical sites across the state and/or country? Please indicate the span.
- The program was first conducted in 17 centers in 16 different states. With help from the Block Grant, it is now in the process of being expanded to several additional states.

Is your program model affiliated with a university? If so, please name.
- The program is not associated with a single university. A group of core collaborators from multiple institutions came together to develop the NAVIGATE program. The institutions are:
  o The Zucker Hillside Hospital and the Hofstra North Shore-LIJ School of Medicine
  o The Feinstein Institute for Medical Research
  o Dartmouth University
  o The University of North Carolina at Chapel Hill
  o The University of California at Los Angeles
  o Yale University
  o Boston University
  o SUNY Downstate Medical Center
  o University of Calgary

Please describe the types of training materials that your program has (e.g., for start-up site locations, providers, consumers, families, referral sources, etc.), and please provide a web address/URL if those materials are publicly available.
- NAVIGATE program materials can be found at http://www.navigateconsultants.org. This website contains the following:
  o Team Members Guide
  o IRT Manual
  o IRT Training Videos
  o Family Manual
  o Prescribers Manual
  o Supported Employment and Education Manual

To your knowledge, is your model being used by your state (or other states) in conjunction with the five percent Mental Health Block Grant Set-Aside Requirement? If yes, please indicate if/how you are working with the states to meet this new requirement.
- Yes, the model is being implemented in several states with use of the five percent Block Grant funding. We have made all NAVIGATE materials publicly available on our website,

http://www.navigateconsultants.org. We have also established a training team to work with interested states. The training team will provide initial free consultation to interested parties and is available for a fee to provide training, certification, and consultation on the treatment model.

OnTrackNY

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http://www.practiceinnovations.org/CPIInitiatives/OnTrackNY.aspx

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New York State Psychiatric Institute

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Description

OnTrackNY is an innovative treatment program for adolescents and young adults who recently have had unusual thoughts and behaviors or who have started hearing or seeing things that others do not. OnTrackNY helps people achieve their goals for school, work, and relationships.

OnTrackNY is a multi-disciplinary, team-based Coordinated Specialty Care (CSC) program that provides individualized, recovery-focused treatment and support to young individuals who are experiencing early psychosis and their families. Components of this CSC program, which evolved from the Recovery After an Initial Schizophrenia Episode (RAISE) Connection Program, include pharmacotherapy, wellness and primary care coordination, supportive counseling and psychotherapy, supported education and employment, skills training and substance abuse treatment, family education and support, and case management.

Currently, there are four OnTrackNY programs in the New York City metropolitan area, and an additional eight teams will be implemented throughout New York State in 2014 and 2015. Training of and consultation and technical assistance on the OnTrackNY model are provided by staff at the Center for Practice Innovations at the New York State Psychiatric Institute and Columbia Psychiatry. Further information about the model and training and consultation services can be found at

http://www.practiceinnovations.org/CPIInitiatives/OnTrackNY/tabid/202/Default.aspx.

Please indicate the designated target population for your program, including any information on the diagnoses addressed or other clinical or demographic characteristics.

- OnTrackNY participants are adolescents and young adults, ages 16 to 30, who reside in New York State, and who have experienced psychotic symptoms such as delusions, thought broadcasting, and/or hallucinations for one week or more but less than 24 months. The psychotic symptoms cannot be due to substance use or general medical condition, nor better accounted for by a primary mood disorder. DSM-5 diagnoses such as Schizophrenia, Schizoaffective disorder, Schizophreniform disorder, Delusional disorder, Other specified schizophrenia spectrum and other psychotic disorder, or Unspecified schizophrenia spectrum and other psychotic disorder are addressed.

How does your program identify, recruit, and/or "screen-in" program participants, including public education/awareness strategies that may be employed?

- The OnTrackNY team includes an Outreach and Recruitment Coordinator (O&RC) position who strategizes, coordinates, and implements much of the outreach and referral, eligibility screening and

evaluation, re-directing referrals when individuals are not eligible, and intake activities for eligible individuals, with and for the OnTrackNY team.

Outreach activities varies by OnTrackNY team and by team location and catchment area as they are context specific but generally involve targeting individuals and their families; institutions such as schools, colleges, churches, and other organizations that work with adolescents and young adults in the target age group; and hospitals and healthcare providers, with a special emphasis on pediatricians and primary care providers. The primary aims of the O&RC role are to reduce the duration of untreated psychosis and to provide linkage to specialized early psychosis intervention services. Printed materials, such as brochures and postcards, and in-person presentations to staff at institutions such as schools and hospitals and to other health providers, are most commonly used. In addition, OnTrackNY has begun to develop additional print and e-materials including (1) printed materials for community-level/mass viewing, such as bus/subway ads and billboards; (2) printed materials for targeted-location viewing, such as posters at schools, youth centers, community centers, religious organizations, vocational programs, and health fairs; (3) video-based materials (e.g., public service announcements) to serve as brief videos that can be posted on video-sharing websites (e.g., YouTube, Vimeo) and to the websites of treatment programs; and (4) social media approaches such as Facebook and other apps that can be downloaded onto smart phones, tablets, and other handheld devices.

Once a referral is made to an OnTrackNY team, the O&RC begins the screening and eligibility evaluation process with the young person and his or her family. Referrals are responded to within 24 hours and close contact is maintained with the young person, family members, and if applicable, referring providers, during the eligibility evaluation process. It is important to note that the O&RC is a skilled, masters or doctoral level mental health clinician who is capable of engaging, providing information to, and problem solving with, young people and their families who are trying to make treatment decisions during what is often a confusing, frightening, and overwhelming time.

What array of treatment services and supports make up your program model (and if the model includes specific evidence-based practices, please list the EBPs)?
- The OnTrackNY model is CSC program that includes the following treatments and supports:
    - Individualized Medication Treatment and Wellness Planning
        - Routine monitoring of signs, symptoms, and side effects through standardized questionnaires
        - Pharmacological treatment recommendations based on standardized guidelines
        - Health and wellness planning
    - Psychoeducation, Psychotherapy and Case Management
        - Meetings at the clinic and in the community as needed
        - Frequent in-person contact
        - Problem solving
        - Managing symptoms and distress
        - Understanding psychosis
        - Understanding the individual and his or her experience in the context of affiliated groups and cultures
        - Case management tasks as needed
        - Crisis intervention and management

- Screening of trauma and assessment of trauma related symptoms; and if warranted, brief trauma treatment (adaptation of Brief Trauma Treatment program developed by Kim Mueser and colleagues)
  - o Individualized Safety Planning (informed by safety planning intervention developed by Barbara Stanley)
    - Assessment of history of self-harm
    - Identification of high risk situations
    - Planning for high risk situations
  - o Supported Employment and Education (relevant EBP includes Individual Placement and Support)
    - Assessment
    - Job search and/or school enrollment
    - Follow-along Supports
  - o Family Interventions (informed by family psycho-education models developed by Lisa Dixon and Amy Drapalski)
    - Inclusion of family in all treatment planning and decision making for youth age 17 or younger and with permission for youth age 18 and over
    - Provision of family education as needed and requested by participant and family
    - Individualized family consultation (as needed to address specific problems)
    - Monthly family psycho-education groups
  - o Structured Behavioral Interventions (informed by skills training and substance abuse treatment intervention models developed by Alan Bellack and Melanie Bennett)
    - Social skills training
    - Substance abuse treatment
    - Coping skills training
    - Increased activity based on the principles of behavioral activation

Many of the services used in first-episode programs were originally developed for individuals with longer-term conditions and related disability (e.g., ACT, Supported Housing). What modifications have you made to these programs, if any, to better accommodate the needs of first episode clients?

- OnTrackNY shares many characteristics in common with ACT. They are both team-based models that focus on engagement and have the capacity to go into the community to see clients. Both ACT and OnTrackNY adopt person- and family-centered approaches. However, there are many differences between a traditional ACT model and OnTrackNY. In ACT, individuals have something of a track record of being unable to benefit from office-based services, and most services are supposed to take place in the community. This is not the case for first episode clients. We do not assume that an office-based model does not work, and we try to use the office except when it does not make sense for the treatment element (e.g., Supported Employment), or when a client really needs outreach to stay engaged, or if it would help the alliance or treatment. In other words, OnTrack is flexible, but does not prefer the community over the office except when it really makes sense for the treatment or the client.
- In traditional ACT, clinicians don't have a caseload, but in OnTrackNY, each client does have a primary clinician. We have observed that it is hard for our young clients to relate quickly to the entire team. So, while the team does have responsibility for all the clients, clients do have a primary contact.

- Given that many of our clients are less than 18 years old, we have also worked very closely in OnTrack with the family members and guardians.
- The clinical treatment processes and foci of OnTrack are geared toward young adults with emerging psychosis, as opposed to older adults who may have been struggling to stay out of the hospital.

Are there strategies in place to help ensure fidelity to your program model (and/or to specific EBPs included within that model)? If so, please describe (e.g., what process is in place, what fidelity measures are used, who conducts the fidelity measurement, how frequently is fidelity measured, etc.)?

- We take a very practical approach to fidelity, with measures drawn from information that should be readily available in routine practice settings implementing the program. The fidelity measures support and draw from routine clinical operations. Routine service logs that note for each contact the client, staff involved, whether family was present, and the location of the service (office versus community) support most fidelity measures. The presence of routine clinical forms is used to document that those components of the intervention occurred. For example, if a program expectation is that safety is assessed at intake, then the presence of such a completed safety-assessment form at intake signifies that such an assessment was completed. Routine medication records and associated laboratory orders provide information necessary to assess fidelity to the psychopharmacology components of the intervention. Teams are provided with a table showing, for each intervention component, core expectations and how they are operationalized via summaries of these routinely available data. Teams provide such data to the OnTrackNY administrative team which, in turn, computes the performance metrics and feeds back these data to the teams so that each team can view its performance in relation to other teams.

Are peers involved in your model? If so, please describe their role.

- Peers have been involved in the development of and training in the OnTrackNY model. For example, Patricia Deegan has developed much of the shared decisions making (SDM) tools for individuals and their families, and has trained OnTrackNY clinicians in the use of these tools. In addition, training staff at the Center for Practice Innovations, which includes a peer recovery specialist, is currently working with community stakeholders groups and experts to develop a peer support role within the OnTrackNY model. The program is in the process of developing a peer role who will serve as a team member.

Is the program time-limited, and if so, what is the duration of care?

- The Critical Time Intervention (CTI) model provides the major organizing structure to the activities of OnTrackNY. CTI is a time-limited, three phased yet flexible case management intervention, that is designed to enhance continuity of support during a "critical time" for youth and adults with serious mental illness. The OnTrackNY model is composed of three phases: Phase 1, Engagement with team and initial needs assessment; Phase 2, On-going intervention and monitoring; and Phase 3, Identification of future needs and services transition. The three phases occur over a span of approximately two years.

What outcome measures does the program use to document impact; are there outcomes that can be shared?

- OnTrackNY teams currently complete quarterly client-level reports for each client including eligibility determination, demographic and background information, insurance coverage, gender, race/ethnicity, education, employment, family history, diagnosis, date of onset, medical history, substance use, behavioral patterns, education, employment, family engagement, and MIRECC GAF scores. The MIRECC

GAF scores document the participant's clinical status, social functioning, and occupational functioning. Our key outcomes include participation in work and school, occupational and social functioning, and symptoms and hospitalization.

Program-wide and site-specific reports are also prepared and used by the individual OnTrackNY programs and for overall program management and evaluation. Examples of current reports include: recruitment and evaluation (# referrals, # evaluations, time from eligibility evaluation to intake), team census (# enrolled, length of stay, # discharged), demographic information (age, gender, race/ethnicity, residence), pathway to care (# mental health contacts, # hospitalizations, # school and other contacts), clinical presentation (average time from psychosis onset to early intervention services, diagnosis at entry, use of antipsychotic medication, substance use, suicidality, CGI/MIRECC GAF score), service use (ER use, inpatient hospitalizations and substance abuse treatment), education and employment status, OnTrackNY services provided (community outreach, family involvement, IPS services), and psychopharmacology intervention and monitoring (side effects evaluation and checklist, weight monitoring).

Does the program model operate in a single area, or are there clinical sites across the state and/or country? Please indicate the span.
- Currently there are four OnTrackNY teams in the New York metropolitan area. We have received a SAMHSA Healthy Transitions grant which will fund two additional teams in 2014-5, one in Onandaga County (Syracuse), and the other in New York City. Seven additional OnTrackNY teams throughout the State will be supported by a combination of Mental Health Block Grant and other funds in 2014-15. These programs will be on Long Island, in Western New York State near Buffalo, in Central New York State in Elmira and Broome Counties, and in the Hudson Valley region near Albany.

Is your program model affiliated with a university? If so, please name.
- OnTrackNY is an initiative of the Center for Practice Innovations at Columbia Psychiatry and the New York State Psychiatric Institute. The Center is funded by the New York State Office of Mental Health. Faculty at the Columbia University College of Physicians and Surgeons and the Columbia University Medical Center play a role in program oversight and supervision.

Please describe the types of training materials that your program has (e.g., for start-up site locations, providers, consumers, families, referral sources, etc.), and please provide a web address/URL if those materials are publicly available.
- OnTrackNY manuals (including Team Manual, Psychopharmacology Manual, Primary Clinician Manual, Recovery Coach Manual, IPS Supported Education and Employment Manual, and Outreach and Recruitment Coordinator Manual) are publicly available. RAISE Connection CSC manuals (including CSC for First Episode of Psychosis Manual I- Outreach and Recruitment; and CSC for First Episode Psychosis Manual II- Implementation) are also publicly available. These two sets of manuals can be accessed at http://practiceinnovations.org/OnTrackUSA/tabid/253/Default.aspx.

  In addition, OnTrackNY staff members at the Center for Practice Innovations are available for consultation to assist States and programs in creating detailed CSC implementation and training plans that may include in-person and/or online training and learning collaboratives; and access to the Center's Learning Management System (LMS) which has considerable online resources containing modules,

videos, tools and important readings. A listing of materials available in the LMS is appended to this document.

To your knowledge, is your model being used by your state (or other states) in conjunction with the five percent Mental Health Block Grant Set-Aside Requirement? If yes, please indicate if/how you are working with the states to meet this new requirement.

- The New York State Office of Mental Health is using the 5% Mental Health Block Grant set-aside monies to fund OnTrackNY programs. Staff at the Center for Practice Innovations at the New York State Psychiatric Institute will provide training, consultation, technical assistance, and evaluation of these newly funded teams.

  In addition, the Center for Practice Innovations supports OnTrackUSA, which has already contracted with or is in the process of contracting with programs from seven states to provide CSC training.

In addition to the Program Profile, if you have any published or unpublished studies or reports that you would like for us to include in our environmental scan, please list them here.

- Publications in press or under review:
  - Dixon LB, Goldman HH, Bennett ME, Wang Y, McNamara K, Mendon SJ, Goldstein AB, Choi CWJ, Lee RJ, Lieberman JA, Essock SM: Implementing Coordinated Specialty Care for Early Psychosis: The RAISE Connection Program. *Psychiatric Services* (in press).
  - Essock SM, Goldman HH, Hogan MF, Hepburn BM, Sederer LI, Dixon LB: State Partnerships for First Episode Psychosis Services. *Psychiatric Services* (in press).
  - Essock SM, Nossel IR, McNamara K, Bennett ME, Buchanan RW, Kreyenbuhl JA, Mendon SJ, Goldman HH, Dixon LB: Practical Monitoring of Treatment Fidelity: Examples from a Team-based Intervention for People with Early Psychosis. *Psychiatric Services* (in press).
  - Frank RG, Glied SA, McGuire TG: Paying for Early Interventions in Psychoses: A Three-Part Model. *Psychiatric Services* (in press).
  - Lucksted A, Essock SM, Stevenson J, Mendon SJ, Nossel IR, Goldman HH, Goldstein AB, Dixon LB. Client Views of Engagement in the RAISE Connection Early Psychosis Recovery Program. *Psychiatric Services* (under review as of October 2014).

Early Assessment and Support Alliance (EASA)

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Please indicate the designated target population for your program, including any information on the diagnoses addressed or other clinical or demographic characteristics.

- EASA's primary target population is individuals with early symptoms consistent with onset of schizophrenia or schizoaffective disorder. The program accepts:
    - Individuals residing in Oregon (including college students in other states whose families live in Oregon)
    - Individuals who score into the Psychosis Risk Syndrome on the SIPS (including differential diagnosis screening – we will screen them out if etiology appears more consistent with a different disorder)
    - Individuals who have experienced psychosis going back 12 months or less, with symptoms consistent with either schizophreniform or bipolar spectrum. We recognize that due to diagnostic uncertainty that final diagnosis may not be schizophrenia or schizoaffective disorder; once someone is accepted they can remain in the program up until the point where an effective transition occurs. This can be as long as two years.
    - All Oregon communities accept ages 15 to 25 at a minimum, but this is a guideline – they can accept below and above. Some communities accept down to age 12 and some accept above age 25.
    - All forms of insurance and uninsured are accepted.

How does your program identify, recruit, and/or "screen-in" program participants, including public education/awareness strategies that may be employed?

- We are committed to universal access and flexible, rapid engagement so we maintain access to care without a waiting list and problem solve around how to maintain this as needed.
- Community education is part of the responsibility of local teams and is part of our training, data collection, and fidelity process. We encourage local teams to review the pathway to care of individuals coming into their programs. We do outreach to local and state-level media, and presentations to a wide range of groups. Our training includes tailored messaging.
- All teams use the same name, and all but one use the same logo, which promotes statewide visibility; we have centralized development and sharing of brochures, marketing materials and PowerPoint as well as a statewide website. We use both statewide and local strategies for approaching media and key referent groups. We also partner as much as possible through parallel efforts (e.g., NAMI, and Mental Health First Aid).

- EASA also has a social media presence, including website, Tumblr, Facebook, Twitter, and LinkedIn, although these could probably be used more effectively.
- Each team has an intake person who is part of the team. They provide outreach, consultation/coaching and screening. The majority of people are screened out, so this person also is responsible for working with the referent to identify a better resource and supporting the person's successful engagement with this resource.

What array of treatment services and supports make up your program model (and if the model includes specific evidence-based practices, please list the EBPs)?

- We have practice guidelines that are updated periodically to integrate current EBPs and best practice knowledge. Specific approaches are:
  - Cognitive Behavioral Therapy
  - Individualized Placement and Support (most programs receive separate IPS reviews and are at fidelity) and supported education based on the same principles. Primary modifications are a stronger focus on career development, private sector benefits, and long-term school/training options than is typical in IPS programs.
  - Multi-Family Psychoeducation
  - Team approach using ACT-level staffing and weekly coordination reviewing each individual.
  - Psychiatric prescribing and metabolic monitoring
  - Psychoeducation using versions of models such as Illness Management and Recovery with adaptations for age and explanatory models.
  - Feedback-informed treatment using Duncan Miller's model
  - Dual Diagnosis Treatment using Motivational Interviewing and Harm Reduction Approaches
  - Occupational therapy following standards outlined in our guidelines
  - University of Kansas Strengths Approach
  - We are piloting the use of Cognitive Enhancement Therapy
- In addition, the EASA model incorporates:
  - Systemic infrastructure guidelines similar to the General Organizational Index
  - Access guidelines focused on proactive engagement
  - Participatory decision making, including person-centered planning and system-level approaches
  - Cultural humility and shared explanatory models using system-level and individual-level approaches
  - Peer support
  - Transition planning and ongoing system development

Are there strategies in place to help ensure fidelity to your program model (and/or to specific EBPs included within that model)? If so, please describe (e.g., what process is in place, what fidelity measures are used, who conducts the fidelity measurement, how frequently is fidelity measured, etc.)?

- The EASA Center for Excellence provides every-other-year or more frequent site visits to review fidelity to practice guidelines. We have a fidelity tool we use for that purpose. The fidelity process is provided by the EASA Center for Excellence and senior-level clinicians. The Center for Excellence also provides support for evaluating outcomes and service improvements.

Are peers involved in your model? IF so, please describe their role.

- Some form of peer support is required as part of the model, as well as robust efforts related to participatory decision-making. Peer involvement varies depending on the program, ranging from full-time paid peer support specialists integrated into the team, to local advisory groups and informal peer networking opportunities. EASA has a statewide young adult leadership council made up of EASA graduates which focuses on creating opportunities for peer networking and encouraging the voice of individuals with lived experience to be the driving force in program development.

Is the program time-limited, and if so, what is the duration of care?
- The program is currently two years, but our guidelines encourage active involvement of graduates and the ability to provide check-ins and advocacy post-graduation. A few programs have developed longer-term vocational supports and one county has developed supported transitional housing available long-term to graduates. There is currently a process of reconsideration of the time restriction and it is likely that the program will be restructured based on current knowledge and feedback from families and participants.

What outcome measures does the program use to document impact; are there outcomes that can be shared?
- Successful engagement into care, family engagement, hospitalizations, legal involvement, substance abuse, living situation, school, and work involvement.

Does the program model operate in a single area, or are there clinical sites across the state and/or country? Please indicate the span.
- Statewide in Oregon. We are close to universal coverage, but there are remaining counties we are working to bring on board. Those counties are either very rural or have systemic issues which have prevented them from requesting funds when they are available.

Is your program model affiliated with a university? If so, please name.
- The model was not developed by a specific university but the EASA Center for Excellence was created in 2013 at Portland State University Regional Research Institute. The EASA Center for Excellence is responsible for statewide training, technical assistance and consultation, fidelity review, program monitoring and development. Because of its placement within the Regional Research Institute, the EASA Center for Excellence is part of the national Technical Assistance Network for Children's Mental Health and the Pathways Research and Training Center. EASA also has strong connections with Oregon Health and Science University Child and Adult Psychiatry Department, and with Pacific University's Occupational Therapy Program.

Please describe the types of training materials that your program has (e.g., for start-up site locations, providers, consumers, families, referral sources, etc.), and please provide a web address/URL if those materials are publicly available.
- We recently completed three national webinars, which are available on www.easacommunity.org.

    We provide introductory, differential diagnosis and SIPS training, and multi-family psychoeducation training every six to 12 months, and periodically have individuals from other states join these trainings. We provide routine consultation calls for clinicians and technical assistance visits to our network. Most of our sites are also receptive to visitors. We put almost all of our training and materials and samples of

various forms and procedures, as well as supportive materials for individuals with psychosis and families on our website.

To your knowledge, is your model being used by your state (or other states) in conjunction with the five percent Mental Health Block Grant Set-Aside Requirement? If yes, please indicate if/how you are working with the states to meet this new requirement.

- Oregon's level of investment in early psychosis intervention already far exceeds the Mental Health Block Grant requirements, and EASA is an integral priority within the Oregon Health Authority. The Mental Health Block Grant is being used to help transition into a more sustainable model supported by expanded coverage under health care reform.

Prevention and Recovery in Early Psychosis (PREP)

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Please indicate the designated target population for your program, including any information on the diagnoses addressed or other clinical or demographic characteristics.

Site	Open	Age	Diagnosis Accepted	Insurance	Funding
PREP San Francisco	2009	14-35	Schizophrenia, Schizophreniform, Schizoaffective Disorder, Psychosis NOS, UHR. Onset within last five years.	All insurance and uninsured. Will see out-of-county on case by case basis.	MHSA
PREP Alameda County	2010	16-24	Schizophrenia, Schizophreniform, Schizoaffective Disorder. Onset within last two years.	MediCal, Health Pac and uninsured Alameda County Residents only	MHSA
PREP San Mateo County	2012	14-35	Schizophrenia, Schizoaffective Disorder, Schizophreniform, Psychosis NOS. Onset within last two years.	All insurance and uninsured San Mateo County Residents	MHSA
PREP Monterey County	2013	14-35	Schizophrenia, Schizoaffective Disorder, Schizophreniform, Psychosis NOS. Onset within last two years.	All insurance and uninsured Monterey County residents only	Federal Programs
PREP San Joaquin County	2013	14-35	Schizophrenia, Schizoaffective Disorder, Schizophreniform, Psychosis NOS. Onset within last two years.	All insurance and uninsured San Joaquin County residents only	Federal Programs

How does your program identify, recruit, and/or "screen-in" program participants, including public education/awareness strategies that may be employed?

- Community stakeholder engagement is conducted during the initial service development phase. This involves a half day and full day training on early identification of psychosis, evidence-based treatments for psychosis, the PREP model, and supporting staff in how to talk to young people and their families about psychosis. Participants are identified by the county behavioral health system and include direct line staff (nurse practitioners, psychiatrists, therapists, case managers) and their supervisors for the full day training, and county behavioral health management staff for the half-day training. During this phase connections are also made with local CBOs, including local NAMI chapters and outreach may involve presentations to these organizations separately.

  Once the service is staffed, the team commences direct outreach efforts to local agencies providing information on early psychosis and identification and intervention along with referral information for PREP. Typically outreach presentations are one hour in length, but may be adapted for the needs of the agency. Outreach is conducted to school wellness centers, local youth oriented mental health services,

inpatient units, drug and alcohol teams, and anywhere with participants falling within the PREP demographic.

During the outreach presentations, participants are educated about the referral pathway into PREP. Referrals are accepted from providers, family members, and self-referrals in all sites except one (Alameda County). This includes an initial phone screen to ensure referrals meet basic criteria for assessment (see inclusion criteria for demographics and geographical inclusion criteria above). If the individual is screened positive, they are invited for a diagnostic interview using the SCID to determine eligibility for the program based upon diagnosis and length of illness duration.

In all counties where PREP operates, relationships have been formed with local inpatient and partial hospitalization units for rapid referral of potential PREP clients allowing for staff to screen, and in some cases assess, while the client is still on the inpatient unit.

One PREP site (Alameda County) has an exclusive referral resource from the county's Transitional Aged Team that meets weekly and only accepts patients who have gone through screening with team first. This effectively serves as the initial screening that occurs in the other four sites.

What array of treatment services and supports make up your program model (and if the model includes specific evidence-based practices, please list the EBPs)?

Site	Evidence Based	Intervention
All Sites	Evidence based for this population	Algorithm-based Medication Management (loosely based on Texas Medication Algorithm)
All Sites	Evidence based for this population	Cognitive Behavioral Therapy for Psychosis
All Sites	Evidence based for this population	Psychoeducational Multi-Family Group
All Sites	Evidence based for SMI	Individual Placement and Support
All Sites	Evidence based for SMI	Motivational Interviewing to Address Co-Occurring Substance Abuse
All Sites	Evidence based for SMI	Strength-Based Care Management
All Sites	Evidence based for SMI	Peer-Led Activity Groups, Including Social Skills and Wellness Groups
Two Sites	Evidence based for SMI	Wellness Recovery Action Plan (Wellness Planning is Incorporated into CBT-p in Other Sites)

Many of the services used in first-episode programs were originally developed for individuals with longer-term conditions and related disability (e.g., ACT, Supported Housing). What modifications have you made to these programs, if any, to better accommodate the needs of first episode clients?

- Services provided in youth-friendly, non-stigmatizing settings. ACT was taken as primary care management model and adapted to meet needs of service and youth (i.e., instead of daily clinical meetings, staff meet weekly to discuss all clients). Individualized Placement and Support (IPS) modified to include educational goals and volunteer work to fit with normative activities of same-aged peers.

Are there strategies in place to help ensure fidelity to your program model (and/or to specific EBPs included within that model)? If so, please describe (e.g., what process is in place, what fidelity measures are used, who conducts the fidelity measurement, how frequently is fidelity measured, etc.)?

- Timely Access: Metrics are in place around key program indicators and are reviewed through regular timely access audits conducted by the research team and reviewed by the Associate Director, including:
  - One working day response time to requests for phone screens
  - SCID assessment and feedback completed within three weeks
- Staff productivity: Presented by Program Manager in monthly executive meeting and reviewed by executive team
- Multi-family Group (MFG): Fidelity monitoring conducted through videotape review of a group by MFG trainer to assess competence. Once three tapes are reviewed as competent MFG leader is considered to be QC'd as competent in MFG.
- Assessment:
  - Staff trained in QSANS/SAPS and SCID are expected to submit three audio or video tapes of client interviews using these measures.
  - Tapes are reviewed for competence using internally developed competence rating scale.
  - Clinician must submit three consecutive competent tapes to be considered competent in assessment and able to conduct assessments without direct observation of assessment through taping.
  - All clinicians continue to attend weekly consensus meetings to discuss ratings and ensure internal consistency in clinical rating and diagnosis.
- Cognitive Behavioral Therapy for Psychosis:
  - Staff trained in CBT-p must submit tapes on a monthly basis to be assessed for competence in this approach.
  - Competence is assessed using the Cognitive Therapy Scale – Revised (CTS-R) and tapes are reviewed by the CBT-p supervisor.
  - Clinicians must submit three consecutive competent tapes to be considered competent in this approach.
  - Once competent clinicians submit tapes on a three-monthly and six-monthly basis to ensure clinical practice does not drift from the CBT-p model
  - All clinicians attend weekly CBT-p group supervision
  - CBT-p supervisors are trained on CTS-R rating scale by the clinical director, and tapes are reviewed in CBT-p supervisor supervision on a quarterly basis by the group to ensure consistent IRR.
- Further metrics: Further programmatic fidelity metrics are in development to establish parameters for fidelity to the PREP model across all sites.

Are peers involved in your model? IF so, please describe their role.
- All PREP sites try to actively recruit individuals with lived experience of mental health problems as either care advocates or family partners (individuals who have experience of supporting a loved one with mental health problems).
- Care advocates are involved with initial engagement of youth, developing and running groups, assisting and supporting staff in case management.
- One site (Alameda) has a connection with a local peer-led training system that offers internships for peers. This site accepts a peer-led training system that offers internships for peers. This site accepts a peer intern every six to nine months.

- Family partners connect directly with family members. Where staffing and training allows they also co-lead MFG and other family support groups.

Is the program time-limited, and if so, what is the duration of care?
- Services are offered up to two years. However, discharge from the program is considered based on the client's level of recovery rather than time spent in the program. If they have met their goals prior to the two year point, they are graduated from the program with the understanding that they can return for services within that two year period. Clients who reach the two year mark but are assessed as requiring further services (i.e., completion of MFG, additional wellness planning, crisis stabilization) are allowed to remain in the program until these goals are met.

If your program has a determined length of care, how did you determine the length of your program's episode of care (i.e., the time between assessment/first treatment and discharge from the level of care)?
- Length of care of two years was determined by county contracts. Two years is somewhat flexible depending upon level of recovery. Clients may be discharged earlier, or may receive services for longer if deemed appropriate based on level of need.

What outcome measures does the program use to document impact; are there outcomes that can be shared?
- Clinical Measures:
  - QSANS/SAPS
  - PHQ-9
  - GAD-7
  - Global Functioning – Social and Role
  - Working Alliance Inventory
  - Lack of Judgment and Insight
  - Medication Adherence Rating Scale
  - Altman Mania Rating Scale
- Program/Functioning Measures
  - Service Satisfaction
  - Hospitalization
    - Use of PES/ER
    - Admittance to hospital
    - Number of days in hospital
    - Voluntary/involuntary
  - Employment status
  - Enrollment in school
  - Suicidal ideation and behavior
  - Arrest history
  - Living situation

Does the program model operate in a single area, or are there clinical sites across the state and/or country? Please indicate the span.
- The program operates in five counties (San Francisco, Alameda, Mateo, Monterey, and San Joaquin). The population of these counties, combined, is 4,228,291 persons.

Is your program model affiliated with a university? If so, please name.

- PREP is a community-academic partnership between The Felton Institute and the University of California, San Francisco.

Please describe the types of training materials that your program has (e.g., for start-up site locations, providers, consumers, families, referral sources, etc.), and please provide a web address/URL if those materials are publicly available.

- Internally, a PREP Policies and Procedures Manual is available at all sites to orient new staff to various aspects of the program, including the format of case conference, discharge planning, safe visiting protocol, and risk assessment. Currently, only CBT-p training and follow-up consultation is available to external agencies. The following trainings are available to internal PREP staff:

Topic	Audience	Materials
PREP Orientation Didactic (5 hours)	All staff	Online training
Assessment Training (SCID, QSANS/QSAPS; 2.5 days)	Clinical staff identified to do assessments	Live training with PowerPoint slides and assessment materials
High Yield CBT-p Techniques (6 hours)	All staff	Live training with PowerPoint didactic slides and role play. Clinician receives binder with assessment tools.
High Yield CBT-p Training, Intermediate and Advanced (4 days)	Clinical staff identified to provide CBT-p	Live training with PowerPoint slides, role play, discussion of cases, and live formulation. Clinician receives CBT-p binder with materials including worksheets and formulation tools.
Multi-Family Group Training; offered in collaboration with PIER Training Institute (3 days)	All staff	Live training includes role play and review of psychoeducational slides. Participants receive MFG binder provided by PIER Institute

To your knowledge, is your model being used by your state (or other states) in conjunction with the five percent Mental Health Block Grant Set-Aside Requirement? If yes, please indicate if/how you are working with the states to meet this new requirement.

- Two additional counties have applied to the state to utilize the five percent set-aside funds to train treatment teams in the PREP model, and several other counties have expressed interest. Existing PREP sites will receive additional funds to expand client counts.

University of North Carolina Outreach and Support Intervention Services (OASIS)

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Carr Mill Mall

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Carrboro, NC 27510

Please indicate the designated target population for your program, including any information on the diagnoses addressed or other clinical or demographic characteristics.

- Young adults, ages 16-36
- Within 1.5 hours drive from outpatient clinic
- First episode of psychosis
  - First symptoms within past five years if not medicated with an antipsychotic, and within past three years if medicated with an antipsychotic from previous treatment provider.
- Or at high-risk of developing psychosis:
  - Attenuated psychotic symptoms
  - Persons with first degree relatives with history of psychotic illness
- Consults are offered for those outside of the catchment area secondary to referral by their treating psychiatric provider.

How does your program identify, recruit, and/or "screen-in" program participants, including public education/awareness strategies that may be employed?

- Recruit from local psychiatric inpatient hospitals, outpatient mental health providers, substance/alcohol abuse treatment providers, primary care medical providers, college counseling centers, high school counselors/mental health officers, homeless shelters, community at large. Self-referrals from families and consumers are also accepted.
  - Outreach is conducted through direct contact with referral sources and public and professional education presentations on early psychosis, treatment resources.
- First contact is by phone with the Program Director/Team Leader who conducts pre-screening for eligibility
- Second contact is targeted within 7 days of pre-screening, conducted between licensed clinician and individual, and the family therapist meets with the individual's family for initial evaluation for admission: A comprehensive biopsychosocial assessment is conducted at that time.
- Third contact is within 7 days of initial assessment, conducted between Psychiatrist and individual and their family for final evaluation and determination/collaborative agreement of admission into program.

What array of treatment services and supports make up your program model (and if the model includes specific evidence-based practices, please list the EBPs)?

- The OASIS program offers Recovery Phase specific treatment services for individuals experiencing First Episode Psychosis. The frequency and intensity of services depend on what phase of recovery each individual is in.

- o Medication Management and Optimization – Conducted with Board Certified Psychiatrist, with support of RN level Nurse. Our model emphasized a collaborative approach and shared decision making, including family members as appropriate. Motivational interviewing techniques are used to address insight and adherence. Health and wellness education is offered when indicated and includes areas of healthy eating, exercise, stress reduction and nutritional supplements. Monitoring for metabolic problems related to antipsychotic medications and to chronic mental illness is done routinely. Requirement for patient participation. Weekly participation during the Acute Phase and Early Recovery phase. A participant at OASIS is seen by psychiatrist even if participant refuses medications
- o Individual Therapy consisting of supportive psychotherapy focusing on engagement/case management, psychoeducation about illness management and recovery, stress management techniques (especially to address stress reactivity, e.g. mindfulness, meditation, etc.) and CBTp (Cognitive Behavior Therapy for Psychosis). Conducted by licensed psychotherapist. Frequency weekly in the Acute and Early Recovery phase. Decreased to bi-monthly or monthly in the Sustained Recovery Phase.
- o Family Support Services – Conducted with licensed family therapist in individual family and multi-family group formats providing psychoeducation about illness management and recovery, and support to family network of patient. May be offered to family members even when patient is not engaged in treatment. Frequency weekly or bi-monthly in the Acute and Early Recovery phases. Decreased to monthly and then quarterly basis in the Sustained recovery phase.
- o Co-occurring Substance/Alcohol Abuse Services – Conducted with interdisciplinary team of MD, RN, and licensed clinician. Weekly participation required at first.
- o Recovery Education Group – Conducted quarterly in a group workshop format with licensed clinicians for all new patients. Required for all new patient participation.
- o Relapse Prevention Planning: conducted in Individual Therapy and Family Support Services. Required of all participants.
- o Supported Employment and Education – Conducted with licensed clinician supportive employment and education specialist. Optional for patients as appropriate and desired.
- o Peer Support – Conducted with certified peer support worker. Optional for patients as appropriate and desired.
- o Social Cognition Interaction & Social Skills Training – Conducted with licensed psychologist. Optional for patients as appropriate and desired.
- o Recreational/Social Activity Rehabilitation group once month open to all participants

Are there strategies in place to help ensure fidelity to your program model (and/or to specific EBPs included within that model)? If so, please describe (e.g., what process is in place, what fidelity measures are used, who conducts the fidelity measurement, how frequently is fidelity measured, etc.)?
- We are currently developing fidelity measures and a quality assurance database to monitor fidelity and outcomes.

Are peers involved in your model? IF so, please describe their role.
- Peer Recovery Mentors are involved in the Recovery Education Group offered quarterly.
- We are currently developing a Peer Support position within our model, where a certified peer support worker is available to patients for peer counseling and support, outreach, and service engagement

Is the program time-limited, and if so, what is the duration of care?

- There is no time limit to the program. In particular, we propose that patients who are in stable recovery especially benefit from the relapse prevention planning that occurs with quarterly or twice yearly visits. These may be important in maintaining symptomatic and functional recovery. Patients who develop chronic, disabling psychosis (about 1 in 5 patients with schizophrenia) are referred to other treatment programs (e.g. ACT or other community treatment programs).

What outcome measures does the program use to document impact; are there outcomes that can be shared?

- We are currently addressing Patient Outcomes through the development of a Quality Assurance database.

Does the program model operate in a single area, or are there clinical sites across the state and/or country? Please indicate the span.

- Since 2005, we have operated as an outpatient clinic in Carrboro/Chapel Hill, North Carolina as a part of the UNC Department of Psychiatry, and since 2009 as part of the UNC Center for Excellence in Community Mental Health.
- We are now expanding into a second outpatient clinic located in Raleigh, North Carolina to better serve communities in our eastern area.
- We hope to expand by opening other outpatient clinics in Eastern North Carolina and the Western/Mountain region of North Carolina.

Is your program model affiliated with a university? If so, please name.

- University of North Carolina Chapel Hill School of Medicine.

Please describe the types of training materials that your program has (e.g., for start-up site locations, providers, consumers, families, referral sources, etc.), and please provide a web address/URL if those materials are publicly available.

- We have been developing a Program Toolkit for Clinicians interested in replicating our model of care.
- During our expansion into the second clinic, we will adapt and finalize our Toolkit for future start up providers.
- During our expansion into the second clinic, we will provide consultation, supervision, and direct training to all staff employed in the new clinic, and for any subsequent expansions we will continue to provide assistance.

To your knowledge, is your model being used by your state (or other states) in conjunction with the five percent Mental Health Block Grant Set-Aside Requirement? If yes, please indicate if/how you are working with the states to meet this new requirement.

- Yes, we are planning to open a second OASIS clinic in a urban area about an hour from our Carrboro location.

Reports and Studies:

- Uzenoff, S.R., Graham, K.A., Saade, S., Smith, B.B., and Perkins, D.O. (2012). Evaluation of a multi-element treatment center for early psychosis in the United States. *Social Psychiatry and Psychiatric Epidemiology, 47,* 1607-1615.

Other Information:

Below is a one-page Outreach/Information Overview for the Program.

**Outreach and Support Intervention Services (OASIS) Program at
The University of North Carolina at Chapel Hill**

Hallucinations, delusions, trouble thinking, and disrupted functioning are all symptoms of Psychosis, a troubling and, without treatment, disabling condition of the brain and mind. Many young people with symptoms of early psychosis try to wait it out, in hopes that life will soon return to normal, but without the right kind of help early on, psychosis can get worse and negatively impact a young person's successful development. At OASIS, we know from experience that if people get the help they need when psychosis first begins, they'll have a better chance at getting on with their lives.

The OASIS Program, opened in 2005 through the UNC School of Medicine, now part of the UNC Center for Excellence in Community Mental Health, serves young adults, ages 16-36, within a 90-minute drive of the clinic, who are experiencing First Episode Psychosis (FEP) or are at high-risk of developing First Episode Psychosis. For individuals living outside of the catchment area, comprehensive consultations are offered secondary to a referral by their treating psychiatric provider.

While patients are often referred from local psychiatric hospitals and clinics, we also accept referrals from high schools and colleges, shelters, other health care professionals, concerned community members, families, and individuals themselves. Referrals can expect a first contact with our Program Director and Team Leader for a free phone screening for eligibility. Subsequent contact for eligible referrals include individual comprehensive assessment by a licensed clinician, along with family evaluation by a family therapist, within 7 days of first phone contact, and a psychiatric evaluation with a board certified psychiatrist within 7 days of the individual and family assessment. Once accepted into the program, patients and families are engaged in intensive and comprehensive treatment services to initiate and maximize a patient's recovery from First Episode Psychosis.

We offer evidence-based, Recovery-Phase-specific treatment services for our patients including:

- Medication Management and Optimization
- Individual Therapy and Recovery Support
- Family Therapy and Support Services
- Co-Occurring Substance/Alcohol Abuse Treatment Services
- Recovery Education Groups
- Relapse Prevention Planning
- Supported Employment and Education
- Peer Support Services
- Social Cognition Interaction Training and Social Skills Training
- Recreational/Social Activity Rehabilitation Groups

There is no time limit to participation in the program. In particular, we propose that patients who are in stable recovery especially benefit from the relapse prevention planning that occurs with quarterly or twice yearly visits, as these may be important in maintaining symptomatic and functional recovery. Patients who develop chronic, disabling psychosis are referred to other treatment programs.

Expansions of OASIS clinics and training of new First Episode Psychosis Clinics in North Carolina is underway currently to expand access to our services, and decrease untreated First Episode Psychosis.

For more information about the OASIS Program at UNC, please visit us on the internet at http://www.med.unc.edu/psych/cecmh/patient-client-information/oasis or call (919) 962-1401.

<h1 style="text-align:center">Specialized Treatment in Early Psychosis (Yale STEP)</h1>

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http://medicine.yale.edu/psychiatry/step/

34 Park Street

New Haven, CT 06519

Please indicate the designated target population for your program, including any information on the diagnoses addressed or other clinical or demographic characteristics.

- STEP primarily targets transition age youth, the group with the highest rate of new onset psychosis, accepting individuals between the ages of 16 to 35 with a primary diagnosis of a non-affective psychotic disorder (e.g. Schizophrenia; Schizophreniform; Schizoaffective Disorder; Psychotic Disorder, Not Otherwise Specified; Schizotypal Personality Disorder). We seek to treat individuals as early as possible after onset of diagnosable psychotic symptoms, accepting persons within the first three years of onset. Our exclusion criteria include monolingual in a language other than English, Intellectual Disability diagnosis, and organic or substance induced psychoses.

  The data below represent the first five years of STEP, which opened in 2006, and our first clinical trial (Srihari, et al., Psychiatric Services, 2015 in press):

Clinical Characteristics at Admission to STEP (n=149)	
Co-Morbid Substance Use Disorder	45%
Previously Psychiatrically Hospitalized	89%
Previous Suicide Attempt(s)	9%
Unemployed	61%
Median DUP (Interquartile range)	4 months (11)**
Schizophrenia or Schizoaffective Diagnosis	29%
**Negatively skewed with ~50% at or below three months. Mean (SD): 11 months (17)	

Demographics	STEP Participants (n=149)
Age, mean (SD) years	22.9 (4.8)
Gender, male, n(%)	121 (80%)
Race/Ethnicity, n (%)	
African American	63 (42%)
White	58 (39%)
Latino/a	21 (14%)
Asian	3 (2%)
Multi-racial	4 (3%)
Immigrant/First Generation	43 (29%)

How does your program identify, recruit, and/or "screen-in" program participants, including public education/awareness strategies that may be employed?

- STEP conducts outreach to mental health professionals in the Greater New Haven area, such as the local psychiatric hospital and emergency departments (ED). We provide information regarding our treatment

program and admission criteria in educational presentations about psychosis and the importance of early intervention and provide brochures, flyers, and business cards. Screenings of potential referrals are typically via phone or in person at the hospital or ED. STEP has presented to a variety of mental health agencies and a few community organizations (e.g. NAMI) about the importance of early intervention for psychosis and how to refer to STEP. We also partner with the psychosis risk clinic PRIME, which conducts extensive professional outreach and education to schools, mental health organizations, universities, etc regarding early detection of psychosis and includes information about referring to STEP.

In February 2015, STEP will launch a campaign to reduce the Duration of Untreated Psychosis. This campaign, titled "MindMap," will include three major components: 1) Professional Outreach and Detailing of a wide variety of community referral sources, 2) a Public Education campaign that will utilize social and mass media outlets, and 3) a Performance Improvement strategy to hasten the time between referral to, and engagement with, treatment at STEP. This campaign is part of an NIH quasi-experimental study that will test over three years the effectiveness of this campaign in reducing DUP compared to the measures at the control site, which is the PREP clinic at Boston (ClinicalTrials.gov NCT02069925).

What array of treatment services and supports make up your program model (and if the model includes specific evidence-based practices, please list the EBPs)?
- Patients in STEP are assigned to a primary clinician who provides individual therapy and case management and facilitates participation in other treatment components: medication management, family treatment, supported employment/education, and social group. The evidence-based practices that comprise these services are Family Focused Therapy (FFT) and Multifamily Group Psychoeducation and Support (MFG), Individual Placement and Support (Supported Employment), Social Cognition Interactive Training (SCIT), and Cognitive Behavior Therapy (CBT).

Are there strategies in place to help ensure fidelity to your program model (and/or to specific EBPs included within that model)? If so, please describe (e.g., what process is in place, what fidelity measures are used, who conducts the fidelity measurement, how frequently is fidelity measured, etc.)?
- Fidelity is not currently formally assessed using fidelity measures/scales. We use outcome "benchmarks" that are regularly assessed at clinical rounds and also draw from assessments by independent research staff. Benchmarks include the percentage of patients who are working, have avoided re-hospitalization at one year, or are experiencing symptom remission. Clinicians participate in weekly supervision for the family interventions and twice monthly SCIT supervision.

Are peers involved in your model? If so, please describe their role.
- Not clinically at this time. We are exploring funding mechanisms to hire a peer staff person to assist with client outreach and engagement. We have had peer participation in development of our early detection campaign (MindMap) and have a peer consultant on this project to advise on campaign messaging and strategies.

Is the program time-limited, and if so, what is the duration of care?
- STEP was not time limited, but as of 2014 the program transitioned to two years treatment duration. At the completion of this period of early intervention, patients will be transferred to a range of ambulatory services depending on their insurance status. The clinic is actively building relationships with private

clinics/providers, and federally-qualified health centers that will serve as sources of referral for "first break" patients, but also receive STEP graduates back into care. Patients who are unable to procure commercial or federal insurance will be transferred to one of the regular ambulatory teams at the Connecticut Mental Health Center, which is the present home of STEP.

What outcome measures does the program use to document impact; are there outcomes that can be shared?

- Current outcome measures include:

Outcome	Measure(s)
Neurocognitive & Social Cognitive	processing speed: MATRICS symbol digit verbal learning: MATRICS Hopkins verbal learning test social cognition: MATRICS- MSCEIT
Substance Use	Habits inventory Alcohol Use Scale (AUS) Drug Use Scale (DUS) Cannabis Scale
Symptom Severity	Positive and Negative Symptoms of Schizophrenia Scale (PANSS) Calgary Depression
Medication Side Effects	Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS)
Social/Occupational Functioning	Global Social/Role Functioning SIPS modified Global Assessment of Functioning
Service Engagement	Service Engagement Scale (SES)
Service Utilization	Service Use and Resources Form (SURF; modified)
Quality of Life (QOL)	Heinrichs QOL SF-36
Suicidality	Columbia Suicide Severity Rating Scale (C-SSRS)
Aggression	Modified Overt Aggression Scale (MOAS)

Our first clinical trial included similar outcomes measures. Our first set of outcomes are in press in Psychiatric Services. Of the analyses we have completed thus far, our first trial demonstrate significantly reduced hospitalization days and admissions and increased vocational engagement compared to treatment as usual

Does the program model operate in a single area, or are there clinical sites across the state and/or country? Please indicate the span.

- Starting in February 2014, STEP transitioned from being open to all residents of the State of Connecticut to a population health model that will target eight surrounding towns (with a population of roughly 300,000 people and an estimated annual incidence of psychosis of 70 to 100). In combination with the ongoing NIH-funded DUP reduction campaign, the program hopes to improve pathways to care across this region, measure the impact and costs and expand access to this model across the state.

Is your program model affiliated with a university? If so, please name.

- Yes, Yale University School of Medicine. STEP operates out of the Connecticut Mental Health Center, which is a collaboration between the State of Connecticut Department of Mental Health and Addiction Services (DMHAS) and Yale. STEP staff is a mix of Yale and DMHAS employees.

Please describe the types of training materials that your program has (e.g., for start-up site locations, providers, consumers, families, referral sources, etc.), and please provide a web address/URL if those materials are publicly available.

- STEP has manuals describing its approach to a group-based CBT, its overall model of specialized team-based care (available upon request) and has published an approach to family education (Breitborde, NJK, Srihari, VH. (2011). *Family work for first-episode psychosis: A service delivery protocol.* In Psychosis: Causes, Diagnosis and Treatment. Nova Science Publishers, Inc. NY).

- STEP has published on an open-access journal the design and approaches used in its current DUP reduction project (Srihari, VH., Tek, C., Pollard, J., et al. (2014). *Reducing the duration of untreated psychosis and its impact in the U.S.: The STEP-ED study.* BMC Psychiatry; 14(1):335. doi:10.1186/s12888-014-0335-3). More materials relevant to this work will be available at the campaign website http://www.mindmapct.org, and related social media outlets (Twitter, Facebook, Instagram, etc.).

- STEP offers ongoing workshops and handouts to patients and their families regarding a variety of topics (e.g. symptoms of psychosis, diathesis stress model, medications, basics of neurobiology, marijuana use). Some of these resources are available at http://www.step.yale.edu.

To your knowledge, is your model being used by your state (or other states) in conjunction with the five percent Mental Health Block Grant Set-Aside Requirement? If yes, please indicate if/how you are working with the states to meet this new requirement.

- Yes, STEP received funding from the Connecticut Department of Mental Health and Addiction Services via the SAMHSA set aside and has allocated these funds to expand the program's supported employment efforts. The program has provided informal consultation to developing programs in other states, but is not yet aware of any formal replications of our approach to early intervention.

Calgary Early Psychosis Treatment Services

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Canada

Please indicate the designated target population for your program, including any information on the diagnoses addressed or other clinical or demographic characteristics.

- The population of Calgary Zone of Alberta Health Services (Population 1.5 million). Age 15 to 55 presenting with a first episode of psychosis and who has had less than 3 months treatment with an adequate dose of antipsychotic. The diagnoses include those in the DSM V Schizophrenia Spectrum and Other Psychotic Disorders.

How does your program identify, recruit, and/or "screen-in" program participants, including public education/awareness strategies that may be employed?

- There is a single point of entry to mental health service known as ACCESS mental health that receives and allocates mental health referrals to all mental health programs. Family physicians, patients, families, social workers or school counsellors can contact ACCESS mental health in order to initiate a referral. ACCESS mental health screens the referral by phone and forwards all information to the program. In addition referrals are received from general hospital emergency services, inpatient units and community mental health services.

  We have conducted a public education program as part of a research program but it was never funded as an ongoing funded public health program. There is an ongoing education of "gatekeepers" that is family physicians. This is supported by research grants.

What array of treatment services and supports make up your program model (and if the model includes specific evidence-based practices, please list the EBPs)?

1. Case Management: Patient has an assigned a Case Manager (CM) while in the program
2. Antipsychotic Medication Prescription: After diagnostic assessment confirms psychosis and the need for pharmacotherapy, antipsychotic medication is prescribed
3. Antipsychotic Dosing Within Recommendations: Antipsychotic dosing is within government approved guidelines for second-generation antipsychotic medications and between 300 and 600 Chlorpromazine Equivalents for first-generation antipsychotics at 6 months
4. Guided Reduction: Patients who have symptoms for more than one month and have achieved remission for at least one year are offered guided and carefully monitored reduction of antipsychotic medication possibly to the point of discontinuation
5. Clozapine for Medication Resistant Symptoms: Use of Clozapine if individual does not respond adequately after two trials of antipsychotics (equivalent to 10 mg Haloperidol, and over 3 month period), one of which is a second generation antipsychotic
6. Patient Psychoeducation: Provision of at least 12 sessions of individual patient psychoeducation, delivered by clinicians, psychiatrist or in specific group psychoeducation sessions. Includes familial, social, biological and pharmacological perspectives on illness. Patients provided with support, information, and management strategies

7. Family Psychoeducation: Provision of individual or group family psychoeducation to offer illness information and how to recognize signs of relapse, and strategies to decrease tension and stress in family. At least 8 sessions delivered by any clinicians over within first year
8. Individual Cognitive Behaviour Therapy: delivered by an appropriately trained professional, for Treatment Resistant Positive Symptoms or for Residual Anxiety or Depression: CBT is an evidence based treatment that is indicated for treatment resistant positive symptoms or for anxiety or depression after acute treatment of psychosis
9. Individual and / or Group Interventions to Prevent Weight Gain: At least 10 sessions to provide following evidence-supported programs: nutritional counseling, cognitive behavioral therapy and exercise and medication options.
10. Motivational Enhancement or Cognitive Behavioral Therapy for Co-Morbid Substance Use Disorder (SUD): Patient with co-morbid SUD receives 3 or more sessions of Motivational Enhancement (ME) or Cognitive Behaviour Therapy (CBT)
11. Supported Employment (SE): SE is provided to patients interested in participating in competitive paid employment
12. Community Living Skills: Program works in the community, in addition to the office, to develop community living skills for those in need (i.e. social skills training, community living training, transportation training, budgeting, meal planning)

Many of the services used in first-episode programs were originally developed for individuals with longer-term conditions and related disability (e.g., ACT, Supported Housing). What modifications have you made to these programs, if any, to better accommodate the needs of first episode clients?

- Pharmacotherapy: There were few published first-episode psychosis studies, so we aimed to meet schizophrenia clinical practice guidelines with a "go slow, and go low" recommendation resulting in lower average doses.
- Family Therapy: We adapted existing recommendations for chronic schizophrenia to recognize the mix of acute distress, lack of knowledge, and denial of first-episode families. We also had to manage the issue of diagnosis changing with time.
- Co-morbid Addictions: We agreed to include from the start, and emphasized dealing with both problems and minimizing the tendency in patients, families, and clinicians to blame everything on the substance use disorder. Initially, we focused on family and patient psychoeducation and groups, but later emphasized individual motivation enhancement strategies.
- Case Management: We included this for all patients even if they were not labeled chronic or schizophrenia. We emphasized active engagement and encouragement to make a more rapid return to work and school than in the previous schizophrenia practice guidelines.

Are there strategies in place to help ensure fidelity to your program model (and/or to specific EBPs included within that model)? If so, please describe (e.g., what process is in place, what fidelity measures are used, who conducts the fidelity measurement, how frequently is fidelity measured, etc.)?

- See fidelity scale below. This scale has been developed and is being piloted in Canada and the U.S. It has been used to test the Calgary program this year, but there has been no set process in place for fidelity assessment in prior years.

Are peers involved in your model? IF so, please describe their role.

- No.

Is the program time-limited, and if so, what is the duration of care?

- Yes – three years.

If your program has a determined length of care, how did you determine the length of your program's episode of care (i.e., the time between assessment/first treatment and discharge from the level of care)?

- We decided to offer a three-year program because the majority of those who will relapse will have experienced relapse within that time. In addition, it provides time to offer guided medication reduction in the second year if the patient has maintained remission for a year.

What outcome measures does the program use to document impact; are there outcomes that can be shared?

DOMAIN & Performance Measure	Type of Measure
Early Intervention	
1. Time from referral to first appointment	Mean
2. Median duration of untreated psychosis (DUP)	Median
3. Population-based admission rate (age 15 to 55)	Annual incidence
5. Proportion of referrals to EPTS first admitted to inpatient services	Percent
First Episode Psychosis Performance Measures	
1. Proportion declining follow-up at one year, two years and three years	Percent
2. Acute episode medication within guidelines	Percent
3. Cumulative admissions to hospital at one year, two years and 3 years	Percent
4. Education (% participating in education) at one year, two years and 3 years	Percent
5. Work (% in competitive employment) at one year, two years and 3 years	Percent
Safety Measures	
1. Assessment of tardive dyskinesia (TD)	Percent
2. Weight (% with BMI< 25) at one year, two years and 3 years	Percent
3. Attempted Suicide % at one year, two years and 3 years	Percent

Does the program model operate in a single area, or are there clinical sites across the state and/or country? Please indicate the span.

- Serves a zone population of 1.5 million.

Is your program model affiliated with a university? If so, please name.

- University of Calgary.

Please describe the types of training materials that your program has (e.g., for start-up site locations, providers, consumers, families, referral sources, etc.), and please provide a web address/URL if those materials are publicly available.

- None.

Calgary First Episode Psychosis Services, Team Fidelity Scale: (CFEPS-TFS 1.0) ©

October 22, 2014
Fidelity Assessor: _____ Interviewee: _____ Date of Fidelity Assessment:_____

Ratings/Anchor Points	1	2	3	4	5
1. Timely Contact with Referred Individual: Patient with FEP is offered an in-person appointment within two weeks of service receiving referral.	Target met for in-person appointment for 0-19% patients	Target met for in-person appointment for 20-39% patients	Target met for appointment for 40-59% patients	Target met for appointment for 60-79% patients	Target met in-person appointment for 80+% patients
2. Patient and Family Involvement in Assessments: Service engages patient and family in initial assessment to improve quality of assessment and to engage both in treatment program	0-19% of families seen during initial assessment	20-39% of families seen during initial assessment	40-59% of families seen during initial assessment	60-79% of families seen during initial assessment	80+% of families seen during initial assessment
3. Comprehensive Clinical Assessment at Enrollment: Initial assessment includes: 1. Time course of symptoms, change in functioning and substance use; 2. Recent changes in behavior; 3. Risk assessment/harm to self; and 4. Risk assessment/harm to others; 5. Mental status exam; 6. Psychiatric history; 7. Premorbid functioning; 8. Co-morbid medical illness; 9. Co-morbid substance use; 10. Family history	All assessment items found in 0 – 19 % of patients	All assessment items found in 20-39% of patients	All assessment items found in 40-59% of patients	All assessment items found in 60-79% of patients	All assessment items found in 80+% of patients
4. Psychosocial Needs Assessed for Care Plan: Assess and incorporate into Care Plan needs related to: 1. Housing; 2. Employment; 3. Education; 4. Social support; 5. Finances; 6. Basic living skills; 7. Primary care access; 8. Social skills; 9. Family Support; 10. Past trauma; 11. Legal	All items addressed in 0-19% of Care Plans	All items addressed in 20-39% of Care Plans	All items addressed in 40-59% of Care Plans	All items addressed in 60-79 % of Care Plans	All items addressed in 80 +% of Care Plans

5. Individualized Clinical Treatment Plan After initial assessment Patients, Family and Staff develop individualized treatment plan using evidence-supported treatments addressing patient needs, goals and preferences (i.e. clinical treatment plan addresses pharmacotherapy, addictions, weight and mood problems)	0-19% patients receive explicit individualized clinical treatment plan	20-39% patients receive explicit individualized clinical treatment plan	40-59% patients receive explicit individualized clinical treatment plan	60-79% patients receive explicit individualized clinical treatment plan	80+% patients receive explicit individualized clinical treatment plan
6. Antipsychotic Medication Prescription: After diagnostic assessment confirms psychosis and the need for pharmacotherapy, antipsychotic medication is prescribed	0-19% patients receive prescription for antipsychotic medication	20-39 % patients receive prescription for antipsychotic medication	40-59% patients receive prescription for antipsychotic medication	60-79% patients receive prescription for antipsychotic medication	80+% patients receive prescription for antipsychotic medication
7. Antipsychotic Dosing Within Recommendations: Antipsychotic dosing is within government approved guidelines for second-generation antipsychotic medications and between 300 and 600 Chlorpromazine Equivalents for first-generation antipsychotics at 6 months	0-19% patients receive doses within recommendations	20-39 % patients receive dosing within recommendations	40-59% patients receive dosing within recommendations	60-79% patients receive dosing within recommendations	80+% patients receive dosing within recommendations
8. Guided Reduction: Patients who have symptoms for more than one month and have achieved remission for at least one year are offered guided and carefully monitored reduction of antipsychotic medication possibly to the point of discontinuation	0-19% eligible patients receive guided reduction of antipsychotic medication.	20-39 % eligible patients receive guided reduction of antipsychotic medication.	40-59% eligible patients receive guided reduction of antipsychotic medication.	60-79% of eligible patients receive guided reduction of antipsychotic medication.	80+% of eligible patients receive guided reduction of antipsychotic medication.
9. Clozapine for Medication Resistant Symptoms: Use of Clozapine if individual does not respond adequately after two trials of antipsychotics (equivalent to 10 mg	< 2 % patients on Clozapine at 2 years	2-4% patients on Clozapine at 2 years	5-7% patients on Clozapine at 2 years	8-10% patients on Clozapine at 2 years	> 10% patients on Clozapine at 2 years

Haloperidol, and over 3 month period), one of which is a second generation antipsychotic					
10. Patient Psychoeducation: Provision of at least 12 sessions of individual patient psychoeducation, delivered by clinicians, psychiatrist or in specific group psychoeducation sessions. Includes familial, social, biological and pharmacological perspectives on illness. Patients provided with support, information, and management strategies	0-19% patients receive at least 12 sessions of psychoeducation	20-39% patients receive at least 12 sessions of psychoeducation	40-59% patients receive at least 12 sessions of psychoeducation	60-79% patients receive at least 12 sessions of psychoeducation	80+% patients receive at least 12 episodes of psychoeducation
11. Family Psychoeducation Provision of individual or group family psychoeducation to offer illness information and how to recognize signs of relapse, and strategies to decrease tension and stress in family. At least 8 sessions delivered by any clinicians over within first year	0-19% families receive at least 8 sessions of family psychoeducation over 1 year	20-39% families receive at least 8 sessions of psychoeducation over 1 year	40-59% families receive receive at least 8 sessions of family psychoeducation over 1 year	60-79% families receive at least 8 sessions of psychoeducation over 1 year	80+% families receive at least 8 sessions of psychoeducation over 1 year
12. Individual Cognitive Behaviour Therapy, delivered by an appropriately trained professional, for Treatment Resistant Positive Symptoms or for Residual Anxiety or Depression: CBT is an evidence based treatment that is indicated for treatment resistant positive symptoms or for anxiety or depression after acute treatment of psychosis	0-15 % patients participated in at least 10 sessions of CBT	16-20 % patients participated in at least 10 sessions of CBT	21-25% patients participated in at least 10 sessions of CBT	26-30 % patients participated in at least 10 sessions of CBT	> 30% patients participated in at least 10 sessions of CBT

13. **Individual and / or Group Interventions to Prevent Weight Gain**: At least 10 sessions to provide following evidence-supported programs: nutritional counseling, cognitive behavioral therapy and exercise and medication options.	0-19 % patients participated in at least 10 sessions	20-29 % patients participated in at least 10 sessions	30-49 % patients participated in at least 10 sessions of	50-79 % patients participated in at least 10 sessions of	> 80% patients participated in at least 10 sessions of
14. **Annual Formal Comprehensive Assessment Documented in Health Record:** Includes assessment of: 1. Educational, occupational and social functioning; 2. Symptoms; 3. Psychosocial needs; 4. Risk assessment of harm to self or others; 5. Substance use; 6. Metabolic parameters (weight, glucose and lipids); and, 7. Extrapyramidal Side Effects.	7 assessment items found in 20 – 30% of annual assessments	7 assessment items found in 31-39% of annual assessments	7 assessment items found in 40-59% of annual assessments	7 assessment items found in 60-79% of annual assessments	7 assessment items found in 80+% of annual assessments
15. **Assigned Psychiatrist:** Each patient has an assigned psychiatrist who can see patients up to once every two weeks as medications are being adjusted	Psychiatrist works with > 60 patients per 0.2 FTE	Psychiatrist works with 50 - 59 patients per 0.2 FTE	Psychiatrist works with 40 - 49 patients per 0.2FTE	Psychiatrist works with 30 - 39 patients per 0.2 FTE	Psychiatrist works with < 29 patients per 0.2 FTE
16. **Assignment of Case Manager :** Patient has an assigned a Case Manager (CM) while in the program, who is a professionally qualified clinician in nursing, psychology, social work or occupational therapy	0-19% patients have an assigned case manager	20-39% patients have an assigned case manager	40-59% patients have an assigned case manager	60-79% patients have an assigned case manager	80 + % patients have an assigned case manager

17. Motivational Enhancement or Cognitive Behavioral Therapy for Co-Morbid Substance Use Disorder (SUD): Patient with co-morbid SUD receives 3 or more sessions of Motivational Enhancement (ME) or Cognitive Behaviour Therapy (CBT)	0-19% patients with SUD receive at least three sessions of either ME or CBT	20-39% patients with SUD receive at least three sessions of either ME or CBT	40-59% patients with SUD receive at least three sessions of either ME or CBT	60-79% patients with SUD receive at least three sessions of either ME or CBT	80 +% patients with SUD receive at least three sessions of either ME or CBT
18. Supported Employment (SE): SE is provided to patients interested in participating in competitive paid employment	Program staff do not actively assess work interest of patients and do not encourage a return to work	Documented assessment of patient interest in work and encourage patients to apply for jobs	Documented referral to an employment program that does not provide high fidelity SE services	Documented assessment of patients interest in work and referral to a supported employment program that provides high fidelity SE services	Documented assessment of patients interest in work and engagement of them by supported employment specialist (ES) part of FEP team and provides high fidelity SE services
19. Active Engagement and Retention: Use of proactive outreach with community visits to reduce missed appointments, engage individuals with FEP.	0-19% of patients and families receive at least two out-of-office visit to facilitate engagement	20-39% of patients and families receive at least two out-of-office visit to facilitate engagement	40-59% of patients and families receive at least one out-of-office visit to facilitate engagement	60-79% of patients and families receive at least two out-of-office visit to facilitate engagement	>80 % of patients and families receive at least one out-of-office visit to facilitate engagement
20. Community Living Skills: Program works in the community, in addition to the office, to develop community living skills for those in need (i.e. social skills training, community living training, transportation training, budgeting, meal planning)	0-19% of all patients receive community living skills training delivered in community setting	20-39 % of all patients receive community living skills training delivered in community setting	40-59 % of all patients receive community living skills training delivered in community setting	60-79 % of all patients receive community living skills training delivered in community setting	>90 % of all patients receive community living skills training delivered in community setting
21. Crisis Intervention Services: FEP Service delivers, or has links to, crisis response services including crisis lines, mobile response teams, urgent care centres or hospital emergency rooms	Team provides crisis services linkage to crisis services to patient or family up to 8 hours per day 5 days per week	Team provides telephone advice and linkage to crisis services up to 8 hrs per day 5 days per week	Team directly provides crisis outreach 8 hours per day or during office hours 5 days per week	Team provides crisis outreach 8 -12 hours per day 5 days per week	Team provides 24 hr crisis outreach services per day, 7 days per week

TEAM components					
22. Participant/Provider Ratio	51+ patients/ provider FTE	41-50 patients/ provider FTE	31-40 patients/ provider FTE	21-30 patients/ provider FTE	20 or fewer patients/ provider FTE

Target ratio of active patient /provider i.e. team members 20:1					
23. Practicing Team Leader: Masters Level Team Leader has, administrative, supervisory responsibilities and delivers direct clinical services	Team leader provides only administrative managerial direction	Team leader provides administrative direction and ensures clinical supervision by others	Team leader provides administrative direction and supervision to some staff	Team leader provides administrative direction and supervision to all staff	Team leader provides administrative direction and supervision to all staff and some direct clinical service
24. Psychiatrist Role on Team: Psychiatrists are team members who attend team meetings, see patients with other clinicians and are accessible for consultation by team during the work week. .	Psychiatrist does not attend team meetings, sees patients in a separate location and does not share same team health record as FEP clinicians	Psychiatrist does not attend team meetings but sees patients at team location and shares team health records. Does not see patients with other program clinicians. Is not available for consultations	Psychiatrist attends team meetings, does not see patients with other clinicians. Shares team health record but is not available for consultations with staff	Psychiatrist attends team meetings, sees patients with other clinicians, shares same health record but is not available for consultations with staff	Psychiatrist attends team meetings, sees patients with other clinicians, shares same health record and is available for consultations with staff .
25. Multidisciplinary Team: Includes qualified professionals to provide both case management and specific service elements including: 1. Nursing services; 2. Evidence Based Psychotherapy; 3. Addictions services; 4. Supported Employment; 5. Family Education and Support; 6. Social and community living skills; and 7. Case management.	Team delivers 3 or fewer of listed elements	Team delivers 4 of the listed elements	Team delivers 5 of the listed elements	Team delivers 6 of the listed elements	Team delivers 7 of the listed elements
26. Duration of FEP Program: Mandate of FEP Program is to provides service to patients for specified period	FEP program serves patients for 1 year or less	FEP program serves patients for ≥1 year to ≤ 2 years	FEP program serves patients for ≥2 years to ≤ 3 years	FEP program serves patients for ≥3 years to ≤ 4 years	FEP program serves patients for 4+ years
27. Weekly Multi-Disciplinary Team Meetings: Team meetings on a weekly basis with focus on: 1. Case review (new admissions and discharges); 2. Assessment and treatment planning; 3. Discussion of complex cases; & 4. Termination of services	No team meetings held	Monthly team meetings	Team meetings held more often than once a month, but less often than every two weeks	Bi-weekly team meetings	Weekly team meetings

28. Targeted Public Health Education: Provision of education to public, including youth, parents, families, teachers, and employers to facilitate recognition of psychosis and accessing of services. Information delivered via brochures, the internet or by staff or individuals with 'lived experience	No provision of public education	Annual mental health awareness campaigns without specific media components	Annual single media campaign on Early Psychosis	Biannual multimedia campaigns on Early Psychosis	Continuous multimedia campaigns on Early Psychosis
29. Targeted Health / Social Service Provider Education: Provision of information to first-contact professionals, including family physicians, school and University counseling services, Colleges and Technical schools, youth social service agencies, community mental health services, police services, and hospital emergency rooms, and crisis teams.	No targeted education	Annual conference for Professionals	Annual single sector professional and/or consumer provided education	Annual sector professional and consumer provided education	Continuous multi-sector professional and consumer provided education
30. Communication Between FEP and Inpatient services: If there is hospitalization of individual currently enrolled in FEP Service, FEP Service staff contact inpatient staff to be involved in discharge planning and arranging outpatient follow up	0-19% of FEP patients who are admitted to hospital are seen at FEP Service within 15 days of hospital discharge	20-39% of FEP patients who are admitted to hospital are seen at FEP Service within 15 days of hospital discharge	40-59% of FEP patients who are admitted to hospital are seen at FEP Service within 15 days of hospital discharge	60-79% of FEP patients who are admitted to hospital are seen at FEP Service within 15 days of hospital discharge	80+% of FEP patients who are admitted to hospital are seen at FEP Service within 15 days of hospital discharge
31. Explicit Admission Criteria: Program has clearly identified mission to serve specific diagnostic groups and uses measurable and operationally defined criteria to select appropriate referrals. There exists a consistent process of screening and documenting of uncertain cases and those	< 60% population served meet admission criteria	60-69% population served meet admission criteria	70-79% population served meet admission criteria	80-89% population served meet admission criteria	> 90% population served meet admission criteria

with co-morbid substance use.					
32. Population Served: Program has a clearly identified mission to serve a specific geographic population and uses comparison of annual incidence and accepted cases to assess success in reaching all new incidence cases.	0-19% of incident cases are admitted to FEP service based on annual incidence of 20 per 100,000 aged 15 - 45	20-39% of incident cases are admitted to FEP service based on annual incidence of 20 per 100,000 aged 15 - 45	40-59% of incident cases are admitted to FEP service based on annual incidence of 20 per 100,000 aged 15 - 45	60-79% of incident cases are admitted to FEP service based on annual incidence of 20 per 100,000 aged 15 - 45	80+% of incident cases are admitted to FEP service based on annual incidence of 20 per 100,000 aged 15 - 45

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Bipolar Disorder Early Assessment and Management (BEAM) Program

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Description:

BEAM is a newly established service offering interventions to young people with a recent onset of bipolar disorder I. The model is based largely on the PREP model but has not yet gone to full scale in terms of training and interventions offered. It may be considered at this point to be an "emerging service" rather than a fully formed program.

Please indicate the designated target population for your program, including any information on the diagnoses addressed or other clinical or demographic characteristics.

Site	Open	Age	Diagnosis Accepted	Insurance	Funding
BEAM San Francisco	2013	14-35	Diagnosis of Bipolar Disorder I, Experienced at least one manic episode but no more than three.	All insurance and uninsured. Will see out-of-county on case by case basis.	Private grant funding
PREP San Mateo County	2012	14-35	Diagnosis of Bipolar Disorder I, Experienced at least one manic episode but no more than three.	All insurance and uninsured San Mateo County Residents	Private grant funding and community funding

How does your program identify, recruit, and/or "screen-in" program participants, including public education/awareness strategies that may be employed?

- Outreach is conducted to the same agencies identified through PREP outreach (i.e. school wellness centers, local youth oriented mental health services, in-patient units, drug and alcohol teams, and anywhere with participants falling within the PREP demographic). PREP outreach materials in sites with a BEAM component are modified to include information relating to bipolar disorder, BEAM program and interventions offered, and referral pathway for possible BEAM client.
- Referrers use the same referral phone number for PREP and BEAM in the sites where both co-exist. Phone screen in these sites ensure referrals meet basic criteria for assessment (see inclusion criteria for demographics and geographical inclusion criteria above). If the individual is screened positive they are invited for a diagnostic interview using the SCID to determine eligibility for the program based upon diagnosis and length of illness duration (see above for eligibility criteria).
- n all counties where BEAM operates relationships have been formed with local inpatient units to allow for rapid referral of potential PREP clients allowing for staff to screen, and in some cases assess, while the client is still on the inpatient unit.

What array of treatment services and supports make up your program model (and if the model includes specific evidence-based practices, please list the EBPs)?

Site	Evidence Based	Intervention
All Sites	Evidence based for this population	Algorithm-based Medication Management
All Sites	Evidence based for this population	Cognitive Behavioral Therapy for Bipolar Disorder
All Sites	Evidence based for SMI	Individual Placement and Support
All Sites	Evidence based for SMI	Motivational Interviewing to Address Co-Occurring Substance Abuse
All Sites	Evidence based for SMI	Strength-Based Care Management
All Sites	Evidence based for SMI	Peer-Led Activity Groups, Including Social Skills and Wellness Groups

Are there strategies in place to help ensure fidelity to your program model (and/or to specific EBPs included within that model)? If so, please describe (e.g., what process is in place, what fidelity measures are used, who conducts the fidelity measurement, how frequently is fidelity measured, etc.)?

- Timely Access
    - Metrics are in place around key program indicators and are reviewed through regular timely access audit conducted by the research team and reviewed by the Associate Director including:
        - 1 working day response time to requests for phone screens
    - SCID assessment and feedback completed within 3 weeks
- Staff productivity
    - Presented by Program Manager in monthly executive meeting and reviewed by executive team
- Assessment
    - Staff trained in QSANS/SAPS and SCID are expected to submit three video or audio tapes of client interviews using these measures
    - Tapes are reviewed for competence using internally developed competence rating scale
    - Clinician must submit three consecutive competent tapes to be considered competent in assessment and able to conduct assessments without direct observation of assessment through taping
    - All clinicians continue to attend weekly consensus meeting to discuss ratings and ensure internal consistency in clinical rating and diagnosis
- Cognitive Behavioral Therapy for bipolar disorder
    - Staff trained in CB-BD must submit tapes on a monthly basis to be assessed for competence in this approach.
    - Competence is assessed using the Cognitive Therapy Scale-Revised (CTS-R) and tapes are reviewed by the CBT-BD supervisor

- In addition to CTS-R tapes are rated for use of skills specific to CBT-BD using competence scale developed in house. CBT-BD supervisor discusses ratings with CBT-BD consultant who co-supervises BEAM clinicians
- Clinicians must submit three consecutive competent tapes to be considered competent in this approach
- Once competent clinicians submit tapes on a three monthly and then six monthly basis to ensure clinical practice does not drift from CBT-BD model
- All clinicians attend weekly group CBT-BD supervision with supervisor and consultant
- Further metrics: Further programmatic fidelity metrics are in development to establish parameters for 'fidelity to the BEAM model' across sites.

Are peers involved in your model? IF so, please describe their role.
- BEAM draws upon existing PREP staffing. There are no peer providers currently employed in the two sites where BEAM currently operates. This is an area for development as the program grows.

Is the program time-limited, and if so, what is the duration of care?
- BEAM draws upon the same service provision criteria as PREP with adaptations to reflect the different requirements for working with this population. Services are offered up to 2 years. However, discharge from the program is considered based on the client's level of recovery rather than time spent in the program. If they have met their goals prior to the two year point they are graduated from the program with the understanding that they can return for services within that two year period. Clients who reach the two year mark but are assessed as requiring further input (i.e. additional wellness planning, further stabilization) are allowed to remain in the program until these goals are met.

What outcome measures does the program use to document impact; are there outcomes that can be shared?
- Clinical Measures:
  - QSANS/SAPS
  - PHQ-9
  - GAD-7
  - Global Functioning – Social and Role
  - Working Alliance Inventory
  - Lack of Judgment and Insight
  - Medication Adherence Rating Scale
  - Altman Mania Rating Scale
- Program/Functioning Measures
  - Service Satisfaction
  - Hospitalization
    - Use of PES/ER
    - Admittance to hospital
    - Number of days in hospital
    - Voluntary/involuntary
  - Employment status
  - Enrollment in school
  - Suicidal ideation and behavior

- o Arrest history
- o Living situation

Does the program model operate in a single area, or are there clinical sites across the state and/or country? Please indicate the span.

- See table in first question. Population of both counties combined is 1,584,815.

Is your program model affiliated with a university? If so, please name.

- No formal partnership with a university although consultation on medication management and training in CBT-BD provided by UCSF faculty.

Please describe the types of training materials that your program has (e.g., for start-up site locations, providers, consumers, families, referral sources, etc.), and please provide a web address/URL if those materials are publicly available.

- 30 minute outreach/psychoeducation power point presentation developed for county providers regarding the BEAM model, referrals accepted, and referral pathways.
- 4 hour BEAM in-person overview training provided to all BEAM staff
- 3 day CBT for Bipolar disorder training for BEAM clinicians utilizing power point slides, CBT materials, and interactive role play
- 4 hour medication management training for BEAM nurse practitioners using power point slides
- No training materials are currently available for use outside BEAM

To your knowledge, is your model being used by your state (or other states) in conjunction with the five percent Mental Health Block Grant Set-Aside Requirement? If yes, please indicate if/how you are working with the states to meet this new requirement.

- No.

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